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| **C O N F I D E N T I A L** | Print Form | Patient Name Click or tap here to enter text. | Date: Click or tap to enter a date. |

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| **Employee: Complete Parts A & C** | | **Health/Safety Professional: Complete Parts B & D prior to distribution to employee** | | | | | | |
| Part A: Personal Information | | | |  | | | | |
| Last Name: Click or tap here to enter text. | | | | Address: Click or tap here to enter text. | | | | |
| First Name: Click or tap here to enter text. | | | | Click or tap here to enter text. | | | | |
| Date of Birth: Click or tap to enter a date. | | | | City: Click or tap here to enter text. | | | | State: Click or tap here to enter text. |
| Sex:  Male  Female | | | | Postal / Zip Code: Click or tap here to enter text. | | | | Country: Click or tap here to enter text. |
| Employer: Click or tap here to enter text. | | | | Phone No.: Click or tap here to enter text. | | | | |
| Location: Click or tap here to enter text. | | | | Email: Click or tap here to enter text. | | | | |
| Supervisor: Click or tap here to enter text. | | | | Job Title: Click or tap here to enter text. | | | | |
| Part B: Health/Safety Professional: This section MUST be completed  prior to distributing this form to the employee. | | | | | | | | |
| Health Care Professional Name: Click or tap here to enter text. | | | | | | Phone No.: Click or tap here to enter text. | | |
| **Respirator and Safety Equipment to be Worn by Employee** | | | | | | | | |
| Type | Weight | | | | Duration | | Frequency of Use | |
| Air Purifying | Click or tap here to enter text. | | | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Air Line | Click or tap here to enter text. | | | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| SCBA | Click or tap here to enter text. | | | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| 5-Minute Escape Pak | Click or tap here to enter text. | | | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Other: Click or tap here to enter text. | Click or tap here to enter text. | | | | Click or tap here to enter text. | | Click or tap here to enter text. | |
| Additional protective clothing and equipment to be worn: Click or tap here to enter text. | | | | | | | | |
| **Expected Physical Effort** | | | | | | | | |
| Light effort (walking, inspecting, etc.) | | | | | | | | |
| Moderate effort (manual labor, including tool use and lifting <25 lbs.) | | | | | | | | |
| Heavy effort (firefighting, ladder climbing, emergency response duties, and lifting >25 lbs.) | | | | | | | | |
| **Temperature and humidity extremes that may be encountered** | | | | | | | | |
| Extreme cold (below 30° F) | | | Dryness | | | Humidity (above 90%) | | |
| Extreme heat (above 100° F) | | | Wetness | | | Other: Click or tap here to enter text. | | |

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| **C O N F I D E N T I A L** | Print Form | Patient Name Click or tap here to enter text. | Date: Click or tap to enter a date. |

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| Part C: Employee / Applicant | |  | | | |
| * Per **OSHA 25 CFR 1910.134 Respirator Standards,** if you have been selected to wear a respirator, you MUST answer the following questions. * Please contact **Houston Health Services** (see **Part B**) if you would like to discuss any questions in this section. | | | | | |
| Height (ft. in.): Click or tap here to enter text. | | Weight (lbs): Click or tap here to enter text. | | | |
| Work Phone No.: Click or tap here to enter text. | | Best time to reach you at this No.: Click or tap here to enter text. | | | |
| Has your employer told you how to contact the physician or nurse who will review this Questionnaire?  (See "Part B" #1 above) | | | | | Yes  No |
| Can you Read? | | | | | Yes  No |
| Have you worn a respirator?  If YES, what type(s)? Click or tap here to enter text. | | | | | Yes  No |
| Have you worn a respirator during fit testing? | | | | | Yes  No |
| Check the type(s) of respirator you will use:  N, R or P Disposal  Other type (e.g., half or full-piece supplied air): Click or tap here to enter text. | | | | | |
| Consent | | | | | |
| Employee Printed Name: | Click or tap here to enter text. | | Date: | Click or tap to enter a date. | |
| Employee Signature: |  | | | | |

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| Respiratory Medical Evaluation Questionnaire |

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| |  |  |  | | --- | --- | --- | | 1 Tobacco Use | Y | N | | Do you currently smoke tobacco or have you smoked tobacco in the last month? |  |  | | Have you smoked one pack, or more, of cigarettes consistently over the last five years? |  |  | | 2 Have you ever had any of the following conditions? | Y | N | | **Seizures (fits)** |  |  | | Seizure within the last 12 months? |  |  | | **Diabetes (sugar disease)** |  |  | | Has the diabetes ever resulted in a diabetic  coma or insulin shock in the last 5 years? |  |  | | **Allergic reactions that interfere with breathing** |  |  | | **Claustrophobia** (fear of closed-in places) |  |  | | **Trouble smelling odors** |  |  | |  | |  |  |  | | --- | --- | --- | | 3 Have you ever had any of the following  pulmonary or lung problems? | Y | N | | **Asbestosis Exposure** |  |  | | **Asthma** |  |  | | Have you had an asthma attack in the last 5 years? |  |  | | Are you currently on asthma medication? |  |  | | **Chronic bronchitis** |  |  | | Have you seen a doctor or had any hospitalization  for chronic bronchitis in the last 5 years? |  |  | | **Emphysema** |  |  | | Have you been seen by a doctor, or hospitalized,  for emphysema in the last 5 years? |  |  | | Are you currently taking any medication for  emphysema? |  |  | | **Tuberculosis** |  |  | | Has the tuberculosis occurred in the last 3 years? |  |  | | Are you currently taking any medications for the  tuberculosis? |  |  | | Has there been any lung damage as a result of the  tuberculosis? |  |  | |

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| **C O N F I D E N T I A L** | Print Form | Patient Name Click or tap here to enter text. | Date: Click or tap to enter a date. |

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| Respiratory Medical Evaluation Questionnaire, cont. |

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| |  |  |  | | --- | --- | --- | | 3 Have you ever had any of the following  pulmonary or lung problems? (cont.) | Y | N | | **Silicosis** |  |  | | **Pneumothorax (Collapsed Lung)** |  |  | | Has the collapsed lung occurred in the   last 5 years? |  |  | | Has there been any shortness of breath or  permanent lung damage as a result of chest   injury or surgery? |  |  | | **Lung Cancer** |  |  | | **Broken Ribs** |  |  | | Have there been any broken ribs in the   last 5 years? |  |  | | Has there been any resulting shortness of   breath or permanent damage? |  |  | | **Chest Injuries & Chest Surgery** |  |  | | Have you received any chest injuries  or had chest surgery in the last 5 years? |  |  | | Has there been any resulting shortness  of breath or permanent lung damage  as a result of chest injury or surgery? |  |  | | Any other lung problem that you've   been told about? |  |  | | (if YES, describe): Click or tap here to enter text. |  |  | | 4 Do you currently have any of the following symptoms of pulmonary or lung illness? | Y | N | | **Shortness of breath** |  |  | | Shortness of breath when walking fast on  level ground or walking up a slight hill or incline |  |  | | Shortness of breath when walking with other  people at an ordinary pace on level ground |  |  | | Have to stop for breath when walking  at your own pace on level ground |  |  | | Shortness of breath when  washing or dressing yourself |  |  | | Shortness of breath that interferes with your job |  |  | | **Coughing that produces phlegm** (thick sputum) |  |  | | Have you been seen by a doctor or hospitalized   for coughing up phlegm in the last 3 years? |  |  | | Are you currently taking any medications for   the cough? |  |  | |  | |  |  |  | | --- | --- | --- | |  | Y | N | | **Coughing that wakes you up in the morning** |  |  | | Have you been seen by a doctor or hospitalized   for early morning coughing? |  |  | | Currently taking any medications for the cough? |  |  | | **Coughing that occurs mostly when you are  lying down?** |  |  | | Have you been seen by a doctor or hospitalized in  the past 3 years for this lying down cough? |  |  | | Currently taking any medications for the cough? |  |  | | **Coughing up blood in the last month?** |  |  | | Have you been seen by a doctor, or hospitalized,  or coughing up blood in the last 3 years? |  |  | | Are you currently taking any medications   for coughing up blood? |  |  | | **Wheezing** |  |  | | Wheezing that interferes with your job? |  |  | | Chest pain when you breathe deeply? |  |  | | Any other symptoms that you think  may be related to lung problems? |  |  | | (if YES, describe): Click or tap here to enter text. |  |  | | 5 Have you ever had any of the following cardiovascular or heart problems? | Y | N | | **Heart Attack** |  |  | | Hospitalized in the last 5 years for a heart attack? |  |  | | Currently taking medication for a heart attack? |  |  | | **Stroke** |  |  | | Hospitalized in the last 5 years for a stroke? |  |  | | Currently taking any medications for a stroke? |  |  | | **Angina** |  |  | | **Heart Failure** |  |  | | **Swelling in your legs or feet** (not caused by walking) |  |  | | **Heart arrhythmia** (heart beating irregularly) |  |  | | **High Blood Pressure** (hypertension) |  |  | | Currently taking any medications to control it? |  |  | | Is the high blood pressure under control? |  |  | | Any other heart problems you’ve been told about? |  |  | | (if YES, describe): Click or tap here to enter text. |  |  | |

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| **C O N F I D E N T I A L** | Print Form | Patient Name Click or tap here to enter text. | Date: Click or tap to enter a date. |

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| Respiratory Medical Evaluation Questionnaire, cont. |

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| |  |  |  | | --- | --- | --- | | 6 Have you ever had any of the following cardiovascular or heart symptoms? | Y | N | | Frequent pain or tightness in your chest |  |  | | Pain or tightness in your chest during physical activity |  |  | | Pain or tightness in your chest that interferes with your job |  |  | | In the past 2 years have you noticed  your heart stopping or missing a beat? |  |  | | Heartburn or indigestion not related to eating |  |  | | Any other symptoms you think may be related to heart or circulation problems? (if YES, describe): Click or tap here to enter text. |  |  | | 7 Do you currently take medication for any  other of the following problems? |  |  | | Breathing or lung problems |  |  | | Heart Trouble |  |  | | Blood pressure |  |  | | Seizure (fits) |  |  | | 8 Have you ever used a respirator? |  |  | | Eye irritation |  |  | | Skin allergies or rashes |  |  | | Anxiety |  |  | | General weakness or fatigue |  |  | | Any other problems that interfere  with your use of a respirator? |  |  | | (if YES, describe): Click or tap here to enter text. |  |  | |  | |  |  |  | | --- | --- | --- | | 9 Would you like to talk to the health care professional that will review this questionnaire about your answers? | Y | N | | **NOTE:** The physician will only contact you if there are  questions concerning your ability to wear a respirator.  The physician is not available for general consultation. |  |  | | 10 Exposure to hazardous chemicals | Y | N | | At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne  chemicals (e.g., gases, fumes, or dust), or have you  come into skin contact with hazardous chemicals? |  |  | | (if YES, list the chemicals and dates of exposure): Click or tap here to enter text. |  |  | | 11 Have you ever worked with any of the materials, or under any of the conditions, listed below? | Y | N | | Asbestos |  |  | | Silica (e.g., in sandblasting) |  |  | | Tungster Vooblat (e.g., grinding or welding this material) |  |  | | Beryllium |  |  | | Coal (e.g., mining) |  |  | | Iron |  |  | | Tin |  |  | | Dusty Environments |  |  | | Any other hazardous exposures? |  |  | | (if YES, describe): Click or tap here to enter text. |  |  | |

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| If you are selected to wear a **FULL FACEPIECE RESPIRATOR** or **SELF CONTAINED BREATHING APPARATUS (SCBA),**  please answer these additional questions. If you have been selected to use other types of respirators, answering these questions is voluntary. |

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| |  |  |  | | --- | --- | --- | | 12 Lost Vision | Y | N | | Have you ever lost vision in either eye? (Temporarily or permanently)? |  |  | | 13 Do you currently have any of the following  vision problems? | Y | N | | Wear contact lenses |  |  | | Wear glasses |  |  | | Color blind |  |  | | Any other eye or vision problems? |  |  | | Are you unable to perform the functions   of the job as a result of these problems? |  |  | |  | |  |  |  | | --- | --- | --- | | 14 Ears and hearing issues | Y | N | | Have you ever had an injury to your ears, including a broken eardrum? |  |  | | 15 Do you currently have any of the following hearing problems? | Y | N | | Difficulty hearing |  |  | | Wear a hearing aid |  |  | | Any other hearing or ear problem? |  |  | | (if YES, describe): Click or tap here to enter text. |  |  | | 16 Have you ever had a back injury? | Y | N | | Are you unable to perform the functions of  the job as a result of this problem? |  |  | |

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| **C O N F I D E N T I A L** | Print Form | Patient Name Click or tap here to enter text. | Date: Click or tap to enter a date. |

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| Respiratory Medical Evaluation Questionnaire |

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| |  |  |  | | --- | --- | --- | | 17 Do you currently have any of these musculoskeletal problems? | Y | N | | Weakness in your arms, hands, legs, or feet |  |  | | Back pain |  |  | | Difficulty fully moving your arms and legs |  |  | | Pain or stiffness when leaning forward  or backwards at the waist |  |  | | Difficulty fully moving your head up or down |  |  | | Difficulty fully moving your side to side |  |  | |  | |  |  |  | | --- | --- | --- | |  | Y | N | | Difficulty bending at your knees |  |  | | Difficulty squatting to the ground |  |  | | Climbing a flight of stairs or ladder  carrying more than 25 lbs. |  |  | | Any other muscle or skeletal problem that interferes with using a respirator? |  |  | | Are you unable to perform the functions  of your job as a result of this problem? |  |  | |

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| ***This section to be filled out by Health Care Professional*** | | | |
| **Part D: Health Care Professional's Assessment** | | | |
| Based on review of the OSHA Respirator Medical Evaluation Questionnaire, this individual is: | | | |
| Employee Name: Click or tap here to enter text. | | | |
|  | Cleared for Respirator Use | | |
|  | Not Cleared for Respirator Use | | |
|  | Exam Required | | |
|  | Did Not Complete Form | | |
|  | Personal Egress/Self Evacuation Only | | |
| Comments Click or tap here to enter text. | | | |
| **Health Care Professional Information** | | | |
| Health Care Professional Name (print): Click or tap here to enter text. | | | |
| Clinic Name: Click or tap here to enter text. | | | |
| Address: Click or tap here to enter text. | | | City: Click or tap here to enter text. |
| State/Province: Click or tap here to enter text. | | Postal / Zip Code: Click or tap here to enter text. | Country: Click or tap here to enter text. |
| Health Care Professional Signature: | | | Date (mm/dd/yyyy): Click or tap to enter a date. |