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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 haveyou smoked tobacco in the last month? |[ ] [ ]
| Have you smoked one pack, or more, of cigarettesconsistently over the last five years? |[ ] [ ]
| 2 Have you ever had anyof 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** |[ ] [ ]

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| 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? |[ ] [ ]

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|  | 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 followingcardiovascular 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 followingcardiovascular 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 thinkmay 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. |  |  |

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| 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 exposedto 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? |[ ] [ ]

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| 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 |[ ] [ ]

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|  | 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. |