Appendix C **FAU Respirator Medical Evaluation Questionnaire**

To the employee:

You must be allowed to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers. Your supervisor must tell you how to deliver or send this questionnaire to the Health South Clinic physician who will review it.

Part A. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Section 1. Personal information

1. Today's date:_____
2. Your name:_____
   Last First Middle Initial
3. Z Number:_____
4. Birthdate:_____
5. Job title:_____
6. Supervisor:_____
7. Department:_____
8. Campus:_____
9. Work phone number:_____
10. Sex (check one): ☐ Male ☐ Female
11. Your height:_____ft. _____in.
12. Your weight:_____lbs.
13. Has your employer told you how to contact the health care professional who will review this questionnaire? (Check one): ☐ Yes ☐ No
14. Check the type of respirator you will use (you can check more than one category):
    - ☐ filter mask (non-cartridge type only)
    - ☐ half-face
    - ☐ full-face
    - ☐ power air purifying respirator (PAPR)
    - ☐ self contained breathing apparatus (SCBA)
15. Have you ever used a respirator? (Check one): ☐ Yes ☐ No
    If "yes," what type(s):_____

Section 2. Medical information (Mandatory)

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no").

	Yes	No
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you ever had any of the following conditions?		
a. Seizures (fits)	☐	☐
b. Diabetes (sugar disease)	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia (fear of closed-in places)	☐	☐
e. Trouble smelling odors	☐	☐
3. Have you ever had any of the following pulmonary or lung problems?		
f. Asbestosis	☐	☐
g. Asthma	☐	☐
h. Chronic bronchitis	☐	☐
i. Emphysema	☐	☐
j. Pneumonia	☐	☐
k. Tuberculosis	☐	☐
l. Silicosis	☐	☐
m. Pneumothorax (collapsed lung)	☐	☐
n. Lung cancer	☐	☐
o. Broken ribs	☐	☐
p. Any chest injuries or surgeries	☐	☐
q. Any other lung problem that you have been told about	☐	☐
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
d. Have to stop for breath when walking at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐
f. Shortness of breath that interferes with your job	☐	☐
g. Coughing that produces phlegm (thick sputum)	☐	☐
h. Coughing that wakes you early in the morning	☐	☐
i. Coughing that occurs mostly when you are lying down	☐	☐
j. Coughing up blood	☐	☐
k. Wheezing	☐	☐
l. Wheezing that interferes with your job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. Any other symptoms that you think may be related to lung problems	☐	☐

	Yes	No
5. Have you ever had any of the following cardiovascular or heart problems?		
a. Heart attack	☐	☐
b. Stroke	☐	☐
c. Angina	☐	☐
d. Heart failure	☐	☐
e. Swelling in your legs or feet (not caused by walking)	☐	☐
f. Heart arrhythmia (heart beating irregularly)	☐	☐
g. High blood pressure	☐	☐
h. Any other heart problem that you've been told about	☐	☐
6. Have you ever had any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest	☐	☐
b. Pain or tightness in your chest during physical activity	☐	☐
c. Pain or tightness in your chest that interferes with your job	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
e. Heartburn or indigestion that is not related to eating	☐	☐
f. Any other symptoms that you think may be related to heart or circulation problems	☐	☐
7. Do you currently take medication for any of the following problems?		
a. Breathing or lung problems	☐	☐
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures (fits)	☐	☐
e. Are you taking any other medications for any reason (including over-the-counter medications)? If "yes," name the medications if you know them:_____ _____	☐	☐
8. If you have never used a respirator, check the following box and go to question 9.: ☐ If you have used a respirator, have you ever had any of the following problems?		
a. Eye irritation	☐	☐
b. Skin allergies or rashes	☐	☐
c. Anxiety	☐	☐
d. General weakness or fatigue	☐	☐
e. Any other problem that interferes with your use of a respirator	☐	☐
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	☐	☐

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA).
For employees who have been selected to use other types of respirators, answering these questions is voluntary.

	Yes	No
10. Have you ever lost vision in either eye (temporarily or permanently)?	☐	☐
11. Do you:		
a. Wear contact lenses?	☐	☐
b. Wear glasses?	☐	☐
c. Have color blindness?	☐	☐
d. Have any other eye or vision problem?	☐	☐
12. Have you ever had an injury to your ears, including a broken eardrum?	☐	☐
13. Do you currently have any of the following hearing problems?		
a. Difficulty hearing	☐	☐
b. Wear a hearing aid	☐	☐
c. Any other hearing or ear problem	☐	☐
14. Have you ever had a back injury?	☐	☐
15. Do you currently have any of the following musculoskeletal problems?		
a. Weakness in any of your arms, hands, legs, or feet	☐	☐
b. Back pain	☐	☐
c. Difficulty fully moving your arms and legs	☐	☐
d. Pain or stiffness when you lean forward or backward at the waist	☐	☐
e. Difficulty fully moving your head up or down	☐	☐
f. Difficulty fully moving your head side to side	☐	☐
g. Difficulty bending at your knees	☐	☐
h. Difficulty squatting to the ground	☐	☐
i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐	☐
j. Any other muscle or skeletal problem that interferes with using a respirator	☐	☐

Part B. Respirator use information

1. How often and for how long do you use your respirator? (i.e. # of hours per day/week/month) _____ _____
2. What type of activities do you perform **while** wearing your respirator?_____ _____
3. List any additional personal protective equipment (e.g., tyvek, gloves, etc.) worn during respirator use:_____ _____
4. What are the temperature and humidity extremes (highest & lowest) that may be encountered on your job?_____ _____
5. Have you ever worked on a HAZMAT team or with hazardous materials? (Check one): ☐ Yes ☐ No

Signature_____ Date_____