Karen's Mobile Occupational Medicine
4120 Seventh Street Road
Upper Burrell, PA 15068
Phone:724-575-9078 Fax: 724-594-0156

Respirator Evaluation Questionaire

SECTION I:

Date:_____

Last name_____First name_____Male / Female

Address:_____City_____State_____ _____Zip_____

SS#_____Date of birth_____Age:_____

Height_____Weight_____Daytime Phone_____Evening Phone_____

1. Has your employer told you how to contact the healthcare professional who will review this questionnaire? Yes No

2. Check the type of respirator you will use:_____N,R,or P disposable respirator (filter mask, non cartridge type only)
_____other type (half or full face piece type, powered air purifying supplied air, self contained breathing apparatus

3. Have you worn a respirator? Yes No

SECTION II:

1. Do you currently smoke tobacco or have you in the last month Yes No
2. How many packs per day?_____
3. Have you ever had any of the following conditions?
   a. Seizures Yes No
   b. Diabetes Yes No
   c. allergic reactions that interfere with your breathing Yes No
   d. claustrophobia (fear of close spaces) Yes No
   e. trouble smelling odors Yes No
4. Have you ever had any of the following pulmonary or lung problems?
   a. Asbestosis Yes No
   b. Asthma Yes No
   c. chronic bronchitis Yes No
   d. emphysema Yes No
   e. pneumonia Yes No
   f. tuberculosis Yes No
   g. silicosis Yes No
   h. pneumothorax Yes No
   i. lung cancer Yes No
   j. broken ribs Yes No
   k. any chest injuries or surgeries? How long ago?
   l. Any other lung problems that you have been told about? Yes No

5. Do you currently have any of the following symptoms of pulmonary or lung illness?

a. shortness of breath Yes No

a. shortness of breath when walking fast on level ground or walking up a slight hill Yes No

b. shortness of breath when walking with others at an ordinary pace on level ground Yes No

c. do you have to stop for a breath when walking at your own pace on level ground Yes No

d. shortness of breath when walking or dressing yourself Yes No

e. shortness of breath that interferes with your job Yes No

f. coughing that produces phlegm (thick sputum) Yes No

g. coughing that wakes you up early in the morning Yes No

h. coughing that occurs mostly when lying down Yes No

i. coughing up blood in the last month Yes No

j. wheezing Yes No

k. wheezing that interferes with your job Yes No

l. chest pain when you breathe deeply Yes No

m. any other symptoms you think may be related to lung problems Yes No

6. Have you ever had any of the following cardiovascular or heart problems

a. heart attack Yes No

b. stroke Yes No

c. angina Yes No

d. heart failure Yes No

e. swelling in your legs or feet not caused by walking Yes No

f. heart arrhythmia (irregular heart beat) Yes No

g. high blood pressure Yes No

h. any other heart problems you have been told about Yes No

7. Have you had any of the following cardiovascular symptoms

a. frequent pain or tightness in your chest that interferes with your job Yes No

b. pain or tightness in your chest during physical activity Yes No

c. in the last two years, have you noticed that your heart skips a beat Yes No

d. heartburn or indigestion that is not related to eating Yes No

e. any other symptoms that you think may be related to heart or circulatory symptoms Yes No

8. Do you currently take any medications for the following problems

a. breathing or lung problems Yes No

b. heart problems Yes No

c. blood pressure Yes No

d. seizures Yes No

9. If you have used a respirator, have you ever had any of the following problems

a. I have never worn a respirator_____

b. Eye irritation Yes No

c. Skin allergies or rashes Yes No

d. Anxiety Yes No

e. General weakness or fatique Yes No

f. Any other problems that interferes with the use of your respirator Yes No

Employee signature_____Date_____

Physician or CRNP signature_____Date_____

Test results: Cleared Not cleared