Central Occupational Medicine Providers

Comprehensive Industrial Case Management & Treatment Centers

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Patient No 17-_____

Sign In Date _____

Personal Information: Please Print Clearly

Age:	Gender: ☐ Male ☐ Female	Height: Ft Inch	Weight: lbs
Please print phone numbers clearly where COMP Clinic may reach you with any questions.		Cell # Home #	Best time to be reached at this number: Morning: ◯ Noon: ◯ Evening: ◯

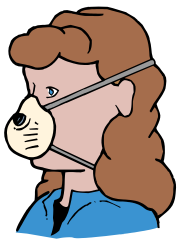
Mandatory Section: Please Check YES or NO

1. Do you currently smoke tobacco or have you smoked tobacco in the last month?	Yes ☐	No ☐
2. Have you ever had any of the following conditions?		
a. Seizures (fits):	Yes ☐	No ☐
b. Diabetes (sugar disease):	Yes ☐	No ☐
c. Allergic reactions that interfere with your breathing:	Yes ☐	No ☐
d. Claustrophobia (fear of closed in places):	Yes ☐	No ☐
e. Trouble smelling odors:	Yes ☐	No ☐
3. 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 (collapsed lung):	Yes ☐	No ☐
i. Lung cancer:	Yes ☐	No ☐
j. Broken rib(s):	Yes ☐	No ☐
k. Any chest injuries or surgeries:	Yes ☐	No ☐
l. Any other lung problems that you've been told about:	Yes ☐	No ☐
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath:	Yes ☐	No ☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	Yes ☐	No ☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes ☐	No ☐
d. Have to stop for breath when walking at your own pace on level ground:	Yes ☐	No ☐
e. Shortness of breath when washing or dressing yourself:	Yes ☐	No ☐
f. Shortness of breath that interferes with your job:	Yes ☐	No ☐
g. Coughing that produces phlegm (thick sputum):	Yes ☐	No ☐
h. Coughing that wakes you early in the morning:	Yes ☐	No ☐

i. Coughing that occurs mostly when you are lying down:	Yes ☐	No ☐
j. Coughing up blood in the last month:	Yes ☐	No ☐
k. Wheezing:	Yes ☐	No ☐
l. Wheezing that interferes with your job:	Yes ☐	No ☐
m. Chest pain when you breathe deeply:	Yes ☐	No ☐
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:	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 (heart beat irregularly):	Yes ☐	No ☐
g. High blood pressure:	Yes ☐	No ☐
h. Any other heart problems that you've been told about:	Yes ☐	No ☐
6. Have you ever had any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest:	Yes ☐	No ☐
b. Pain or tightness in your chest during physical activity:	Yes ☐	No ☐
c. Pain or tightness in your chest that interferes with your job:	Yes ☐	No ☐
d. In the past two years, have you noticed your heart skipping or missing a beat:	Yes ☐	No ☐
e. Heartburn or indigestion that is not related to eating:	Yes ☐	No ☐
f. Any other problems that you think may be related to heart or circulation problems:	Yes ☐	No ☐
7. Do you currently take medication for any of the following problems?		
a. Breathing or lung problems:	Yes ☐	No ☐
b. Heart trouble:	Yes ☐	No ☐
c. Blood pressure	Yes ☐	No ☐
d. Seizures (fits):	Yes ☐	No ☐
8. If you've used a respirator, have you ever had any of the following problems? (If never used, check the box to the left and go to question #9)	Never used: ❒	
a. Eye irritation:	Yes ☐	No ☐
b. Skin allergies or rashes:	Yes ☐	No ☐
c. Anxiety:	Yes ☐	No ☐
d. General weakness or fatigue:	Yes ☐	No ☐
e. Any other problem that interferes with your use of a respirator:	Yes ☐	No ☐
9. Do you feel that you need to talk to a Professional License Health Practice Practitioner at "COMP" Medical Clinic who will review the questionnaire about your answers?	Yes ☐	No ☐

Medical Recommendations for use of Respiratory Protective Equipment



Last Four Digit of SSN:	**XXX –XX -_____**	
Employee Number:	Last Name:	First Name:
Job Trade/Title:	Name of Superintendent/Supervisor:	
	Company Name:	

1. Have you worn a Respirator before? Please circle one: Yes or No
2. If yes, what type(s):_____?
3. If yes, average hour(s) used: _____?
4. Which type of Respirator will you be using at your company?
   - **a. Disposable Filter Respirator**
   - **b. ½ face Air Purifying Respirator with Organic Vapor Cartridge and Pre Paint Filter.**
   - **c. Both**

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Based on the information provided to me and on my evaluation of the Respirator Medical Evaluation Questionnaire, it is my opinion that the aforementioned applicant/employee is:

- Medical Qualified for the use of respirators.
- In need of a Limited Medical Examination_____

_____

Comments: _____

_____

Clinician: _____

Print Name (Professional Licensed Healthcare Provider)

_____ _____

Signature (Professional Licensed Healthcare Provider) Date

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FIT TEST RESULTS

Patient No 17-_____

Sign In Date _____

EMPLOYEE CLASSIFICATION FOR THE USE OF RESPIRATORY PROTECTIVE DEVICES

First Name : _____ Last Name :_____

SSN _____-_____-_____

Date of Birth _____

I hereby certify that on _____, I examined the aforementioned individual for contraindications to the use of a respiratory protective device and found him/her:

☐ CLASS I Medically qualified for unlimited use of respiratory protective devices

☐ CLASS II Medically qualified for limited use of respiratory protective devise, up to a maximum of _____ hours per day.

☐ CLASS III Medically qualified for use of respiratory protective devices ***only in case of emergency***.

Qualitative Fit Test Record

Respirator: _____ Size: _____

Respiratory Hazards Encountered: _____

Sensitivity Test:		**Results:**
• Isoamyl Acetate (Banana Oil)		Pass ( ) Fail ( ) NA ( )
• Saccharin #Squeezes 10 ( ) 20 ( ) 30 ( )		Pass ( ) Fail ( ) NA ( )
• Irritant Smoke		Pass ( ) Fail ( ) NA ( )
Fit Test Agent:	**Filter/Cartridge:**	**Results:**
• Isoamyl Acetate	Organic Vapor Cartridge	Pass ( ) Fail ( ) NA ( )
• Saccharin	Particulate Filter	Pass ( ) Fail ( ) NA ( )
• Irritant Smoke	High Efficiency Filter	Pass ( ) Fail ( ) NA ( )

Comments: _____

Fit Test Repeated Before: _____

Test Conductor: _____

Employee Signature: _____

Respirator Fit testing

IMPORTANT Please be advised that during the Respirator fit testing you will be expected to complete the following steps (1-7) when you are wearing your mask. The intention of these steps is to ensure a proper fit of the N95 disposable Mask and to ensure that test equipment is in proper working order and meet Occupational Safety and Health Administration (OSHA) standards that have been put in place for the safety of employees like yourself. Please be advised that these steps could take up to 30 minutes to complete.

1) Normal breathing – In a normal standing position, without talking, the subject shall breath normally.
2) Deep breathing – In a normal standing position, the subject shall breathe slowly and deeply, taking caution so as not to hyperventilate.
3) Turning head side to side – standing in place, the subject shall slowly turn his/her head from side to side between the extreme positions on each side. The head shall be held at each extreme momentarily, so the subject can inhale at each side.
4) Moving head up and down – standing in place, the subject shall slowly move his/her head up and down. The subject shall be instructed to inhale in the up position (when looking toward the ceiling).
5) Talking – The subject shall talk out loud slowly and loud enough so as to be heard clearly by the test conductor.
6) Bending over – The test subject shall bend at the waist as if he/she were to touch his/her toes. Jogging in place may be substituted for the exercise.
7) Normal breathing – Same as exercise 1 above.

By signing this document I am certifying that I have read and understand the information above.

_____ _____

Signature Date