This questionnaire is used in determining whether or not you have a medical condition, which may affect your ability to wear a respirator. In some cases, we may ask for more information, or you will be required to undergo a medical respirator exam. Fit testing is also required and is done separately. All medical information is considered confidential.

THE FOLLOWING INFORMATION MUST BE COMPLETED FOR RESPIRATOR APPROVAL.

TO BE COMPLETED BY SUPERVISOR:

EMPLOYEE NAME	BIRTH DATE / /
EMPLOYER	EMPLOYER PHONE
SUPERVISOR	PROJECT/ JOB

1. Respirator type *(Check all that apply.)*
   ☐ dust/mist mask ☐ canister/cartridge ☐ SCBA
   ☐ other _____
2. Number of days per week respirator is used:
   ☐ less than 1 ☐ 1-4 ☐ almost every day
3. Current or potential exposure requiring a respirator _____
4. Other work considerations such as: high places, temperature, hazardous material, etc. _____
5. When using respirator, work is:
   ☐ light ☐ moderate ☐ heavy ☐ strenuous
6. Length of time respirator is worn during day:
   ☐ less than 1 hour ☐ 1-5 hours ☐ 5-12 hours

X _____
SUPERVISOR SIGNATURE

TO BE COMPLETED BY EMPLOYEE:

HAVE YOU EVER WORKED IN ANY OF THE FOLLOWING OCCUPATIONS?	NO	YES	WHEN
FOUNDRY			
MINE			
QUARRY			
ASBESTOS			
SANDBLASTING			
TEXTILE MILL			
DUST, FUMES, CHEMICALS			

QUESTIONNAIRE	YES	NO
1. Have you ever experienced difficulty wearing a respirator?		
2. Do you have shortness of breath at rest?		
3. Do you have shortness of breath, when walking at a normal pace on flat ground?		
4. Do you have a chronic cough? If yes, is it a productive cough? ☐ Y ☐ N How much?_____		
5. Do you have asthma?		
6. Do you have wheezing?		

Allina Health

PERIODIC RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

309AOH (11/13)

PATIENT LABEL

QUESTIONNAIRE	YES	NO
7. Do you get short of breath at work?		
8. Do you get chest pain with activity?		
9. Do you get chest pain at work?		
10. Have you had any recent injury to your ears, drainage from your ears, or ear pain?		
11. Do you wear a hearing aid or have any problem with your hearing?		
12. Are you afraid of tight or enclosed spaces?		
13. Do you wear glasses or contact lenses?		
14. Any eye surgery or cataracts?		
15. Do you have any visual problems?		
16. Do you have a beard or mustache?		
17. Are you taking any prescription or over-the-counter medications? *(If yes, list names of medications.)*		
18. Have you ever been told by a physician that you have any of the following? *(If yes, check all that apply.)* ☐ Angina ☐ Heart surgery ☐ Asthma ☐ Tuberculosis (TB) ☐ Heart attack ☐ High blood pressure ☐ Chronic lung disease ☐ Ruptured ear drum ☐ Heart disease ☐ Seizure disorder ☐ Emphysema ☐ Diabetes: ○ Pills ○ Insulin ○ Diet controlled		
19. Punctured ear drum?		
20. Impaired or non-existent sense of smell?		
21. Are you currently under a doctor's care?		
22. Any major surgery/injury? If yes, please explain:		
23. Do you smoke: ☐ pipe ☐ cigars ☐ cigarettes? If yes, how may per day?_____ # years?_____		
24. Are you an ex-smoker? How much did you smoke per day?_____ # years?_____		
25. Have you ever stayed in a hospital over night? *(If yes, please explain.)*		
26. Have you ever had any of the following? *(If yes, check all that apply.)* ☐ Skin allergies ☐ Allergic to chemicals ☐ Latex allergy ☐ Other skin problems		

X _____ / /

EMPLOYEE SIGNATURE DATE

FOR OFFICE USE ONLY:

EMPLOYEE NAME			COMPANY	
HT.	WT.	BLOOD PRESSURE	PULSE min.	POST EXERCISE PULSE min.

SMOKING:
☐ No / Never ☐ Yes / Currently ☐ Quit # Years _____ # Packs/day _____

CHEST X-RAY WITHIN NORMAL LIMITS: ☐ No ☐ Yes ☐ N/A

SPIROMETRY RESULTS WITHIN NORMAL LIMITS: ☐ No ☐ Yes ☐ N/A

PHYSICAL EXAM	N	Ab	PHYSICAL EXAM	N	Ab
1. Eyes			8. Beard/mustache		
2. Nose			9. Neck		
3. Oropharynx			10. Lung		
4. Teeth			11. Heart		
5. Outer ear			12. Extremities		
6. Ear canal			13. Other:		
7. TM's					

X _____ / /

PHYSICIAN SIGNATURE DATE