Single (F4-1)

EMPLOYEE NAME	SS #
COMPANY	

TO BE COMPLETED BY PHYSICIAN

I HAVE EXAMINED THE INDIVIDUAL ABOVE AND FIND: ***(check one)***

☐ **1.** Employee approved for respirator use.

☐ **2.** Employee approved for respirator use with the following restriction(s):

☐ **3.** Medical recommendation reserved pending additional medical information or treatment.

☐ **4.** No respirator use is permitted for this individual at this time.

☐ **5.** Follow-up is recommended for further evaluation. Explain

THE EMPLOYEE HAS BEEN INFORMED BY ME (the undersigned physician) OF THE RESULTS OF THE MEDICAL EXAMINATION AND PROVIDED WITH A COPY OF THESE FINDINGS. ☐ YES ☐ NO ☐ N/A

MEDICAL QUESTIONNAIRE ONLY:

AFTER REVIEWING THIS QUESTIONNAIRE, I FEEL THIS INDIVIDUAL NEEDS TO BE SEEN OR A MEDICAL EVALUATION AND/OR FOLLOW-UP. HOWEVER, PROPER FIT TESTING IS NEEDED, BEFORE BEING ALLOWED TO WEAR A RESPIRATOR. ☐ YES ☐ NO ☐ N/A

X ______________________ / /

PHYSICIAN SIGNATURE DATE

PHYSICIAN NAME *(please type or print)*

ADDRESS

PHONE

Allina Health

RESPIRATOR PHYSICAL EXAMINATION FINDINGS

PATIENT LABEL

Fold

Employer shall provide supplemental information for the health care provider, before recommendation of an employee's ability to wear a respirator. **Copy of the Employer's Respiratory Protection Program must be provided to the health care provider.**

EMPLOYEE NAME	SOCIAL SECURITY NUMBER

TO BE COMPLETED BY EMPLOYER: ***All information must be completed for Respiratory Approval***

COMPANY		
PROJECT	JOB PHONE	SUPERVISOR

1. **Respirator Type:** *(Check all that apply)*
   ☐ Dust/mist mask ☐ Canister/cartridge ☐ SCBA
   ☐ Other ______ **Weight** ______

2. **Expected physical work effort:**
   ☐ Light ☐ Moderate ☐ Heavy

3. **Days/Week:** *(Including use for rescue & escape)*
   ☐ Less than 1 ☐ 1-4 ☐ Almost every day

4. **Length of time respirator is worn during day:**
   ☐ Less than 1 hour ☐ 1-5 hrs. ☐ 5-12 hrs.

5. **List additional protective clothing & equipment work**

6. **Temperature & humidity extremes which may be encountered**

7. **Any supplemental information**

8. **What substances are you currently or potentially exposed to requiring a respirator?**

X ______________________ / /

SUPERVISOR SIGNATURE DATE

Allina Health

INITIAL RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

PATIENT LABEL

CONTINUE ☞

FITNESS & HISTORY

EMPLOYER:
Answers to questions in Section 1 – and to Question 9 in Section 2 of Part A – do not require a medical examination.

EMPLOYEE: Can you read? ◯ No ◯ Yes
Your employer must allow you 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, and your employer must tell you how to deliver this Questionnaire to the health care professional who will review it.

PART A – SECTION 1 *(Mandatory)*

NAME			DATE
AGE	☐ Male ☐ Female	HEIGHT	WEIGHT
Phone number where you can be reached by the health care professional, who reviews this Questionnaire (include Area Code):	Phone: ( )		Best Time To Call:
JOB TITLE			

1. Has your employer told you how to contact the health care professional, who reviews this Questionnaire?
   ◯ No ◯ Yes

2. Check the type of respirator you will use (you can check more than one category):
   Disposable Respirator: ☐ Non-Oil Resistant ☐ Resistant to Oil ☐ Oil Proof
   (Dust/filter-mask, non-cartridge type only)
   ☐ **Other Type:** (*i.e.* half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

3. Have you worn a respirator? ◯ No ◯ Yes – If "Yes," what type(s) ____________

PART A – SECTION 2 *(Mandatory)*

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?**
   a. Asbestosis? .... Ⓝ Ⓨ
   b. Asthma? .... Ⓝ Ⓨ
   c. Chronic bronchitis? .... Ⓝ Ⓨ
   d. Emphysema? .... Ⓝ Ⓨ
   e. Pneumonia? .... Ⓝ Ⓨ
   f. Tuberculosis? .... Ⓝ Ⓨ
   g. Silicosis? .... Ⓝ Ⓨ
   h. Pneumonia? .... Ⓝ Ⓨ
   i. Lung cancer? .... Ⓝ Ⓨ
   j. Coughing up blood in the last month? .... Ⓝ Ⓨ
   k. Any chest injuries or surgeries? .... Ⓝ Ⓨ
   l. Any other lung problem that you have been told about? .... Ⓝ Ⓨ

18. **Provide the following information – if you know it – for each toxic substance to which you will be exposed, when you are using your respirator(s):**
   ❶ Toxic substance ____________
   Estimated maximum exposure level per shift ____________
   Duration of exposure per shift ____________
   ❷ Toxic substance ____________
   Estimated maximum exposure level per shift ____________
   Duration of exposure per shift ____________
   ❸ Toxic substance ____________
   Estimated maximum exposure level per shift ____________
   Duration of exposure per shift ____________
   ❹ The name of any other toxic substances to which you will be exposed, while using your respirator ____________

19. **Describe any special responsibilities you will have, while using your respirator(s), which may affect the safety and well-being of others (*i.e.* rescue, security):**

FOR MEDICAL 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					

Comments ____________

X ____________ PHYSICIAN SIGNATURE

/ / DATE

11. **How often are you expected to use the respirator(s)? (Check all that apply)**
    - a. Escape only (no rescue)? ⓃⓎ
    - b. Emergency rescue only? ⓃⓎ
    - c. Less than 5 hours per week? ⓃⓎ
    - d. Less than 2 hours per day? ⓃⓎ
    - e. 2 to 4 hours per day? ⓃⓎ
    - f. Over 4 hours per day? ⓃⓎ

12. **During the period you are using the respirator(s), is your work effort:**
    - a. **LIGHT** (less than 200 kcal per hour)? ⓃⓎ
      - If "Yes," how long does this period last during the average?

SHIFT	HOURS	MINUTES

__Examples__ of a light work effort are __sitting__ while writing, typing, drafting, or performing light assembly work; or __standing__ while operating a drill press (1-3 lbs.) or controlling machines.

    - b. **MODERATE** (200 to 350 kcal per hour)? ⓃⓎ
      - If "Yes," how long does this period last during the average?

SHIFT	HOURS	MINUTES

__Examples__ of a moderate work effort are __sitting__ while nailing or filing; __driving__ a truck or bus in urban traffic; __standing__ while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; __walking__ on a level surface about 2mph or down a 5° grade about 3mph; or __pushing__ a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

    - c. **HEAVY** (about 350 kcal per hour)? ⓃⓎ
      - If "Yes," how long does this period last during the average?

SHIFT	HOURS	MINUTES

__Examples__ of a heavy work effort are __lifting__ a heavy load (about 50 lbs.) from the floor to your waist or shoulder; __working__ on a loading dock; __shoveling; standing__ while bricklaying or chipping castings; __walking__ up an 8° grade about 2mph; __climbing__ stairs with a heavy load (about 50 lbs.).

13. **Will you be wearing protective clothing and/or equipment (other than the respirator), when you are using your respirator?** ⓃⓎ
    - If "Yes," describe this protective clothing and/or equipment:

____

____

14. **Will you be working under hot conditions (temperature exceeding 77°F)?** ⓃⓎ

15. **Will you be working under humid conditions?** ⓃⓎ

16. **Describe the work you will be doing, while you are using a respirator:**

____

____

____

17. **Describe any special or hazardous conditions you might encounter, when you are using your respirator(s) (*i.e.* confined spaces, life-threatening gases):**

____

____

____

____

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 in the last month? ⓃⓎ
    - 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? ⓃⓎ

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 have 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 2 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)? ⓃⓎ

8. **If you have used a respirator, have you *ever had* any of the following problems?**
    - ☐ I HAVE NEVER USED A RESPIRATOR (PROCEED TO QUESTION 9)
    - 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 a health care professional, who will review this Questionnaire about your answers to this Questionnaire?** ⓃⓎ

PART A – SECTION 2 *(Questions 10-15)*

10. **Have you *ever lost* vision in either eye (temporarily or permanently)?** .... Ⓝ Ⓨ

11. **Do you *currently* have any of the following vision problems?**
    a. Wear contact lenses? .... Ⓝ Ⓨ
    b. Wear glasses? .... Ⓝ Ⓨ
    c. Color blind? .... Ⓝ Ⓨ
    d. Any other eye or vision problem? .... Ⓝ Ⓨ

12. **Have you *ever had* an injury to your ears, including a broken ear drum?** .... Ⓝ Ⓨ

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. 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? .... Ⓝ Ⓨ

Comments ____________________

PART B

1. **In your present job, are you working at high altitudes (over 5,000 feet), or in a place that has lower than normal amounts of oxygen?** .... Ⓝ Ⓨ
   - If "Yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these conditions? .... Ⓝ Ⓨ

2. **At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (*e.g.* gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?** .... Ⓝ Ⓨ
   - If "Yes," name the chemicals, if you know them:

3. **Have you ever worked with any of the materials – or under any of the conditions – listed below?**
   a. Asbestos? .... Ⓝ Ⓨ
   b. Silica (*e.g.* in sandblasting)? .... Ⓝ Ⓨ
   c. Tungsten/cobalt (*e.g.* grinding or welding this material)? .... Ⓝ Ⓨ
   d. Beryllium? .... Ⓝ Ⓨ
   e. Aluminum? .... Ⓝ Ⓨ
   f. Coal (*i.e.* mining)? .... Ⓝ Ⓨ
   g. Iron? .... Ⓝ Ⓨ
   h. Tin? .... Ⓝ Ⓨ
   i. Dusty environments? .... Ⓝ Ⓨ
   j. Any other hazardous exposures? .... Ⓝ Ⓨ
   - If "Yes," describe these exposures:

4. **List any second jobs or side businesses you have:**

5. **List your previous occupations:**

6. **List your current and previous hobbies:**

7. **Have you been in the military services?** .... Ⓝ Ⓨ
   - If "Yes," were you exposed to biological or chemical agents (either in training or in combat)? .... Ⓝ Ⓨ

8. **Have you ever worked on a HazMat Team?** .... Ⓝ Ⓨ

9. **Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this Questionnaire, are you taking any other medications for any reason (including over-the-counter medications)?** .... Ⓝ Ⓨ
   - If "Yes," name the medications, if you know them:

10. **Will you be using any of the following items with your respirator(s)?**
    a. HEPA Filters? .... Ⓝ Ⓨ
    b. Canisters (*i.e.* gas masks)? .... Ⓝ Ⓨ
    c. Cartridges? .... Ⓝ Ⓨ