



Airport Clinic
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4080 West Broadway #200
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Respirator Medical Evaluation Questionnaire

This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to safely wear a respirator. We anticipate being able to approve most people for respirator use based on the questionnaire alone. In some cases, we ask for more information or additional testing/evaluation. Fit testing is also required and is done separately. All medical information is considered confidential.

Part A. Section 1. (Mandatory) The following information is required by OSHA's Respiratory Protection Standard, CFR. 1910.134 for every employee who has been selected to use any type of respirator (please print).

Can you read? [ ] Yes [ ] No

Today's Date: \_\_\_\_\_ Company: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: (date of birth): \_\_\_\_\_ Sex (circle one): Male / Female

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

Job Title: \_\_\_\_\_

A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): \_\_\_\_\_

The best time to phone you at this number: \_\_\_\_\_

YES NO

[ ] [ ] Has your employer told you how to contact the health care professional who will review this questionnaire?

Check the type of respirator you will use (you can check more than one category):

- [ ] N, R, or P disposable respirator (filter- mask, non-cartridge type only)
[ ] Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

[ ] [ ] Have you worn a respirator (check one):
If "yes" what type(s):

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



YES

NO



**Broken Ribs**

If YES, when: \_\_\_\_\_

If YES, any permanent breathing problems: \_\_\_\_\_



**Any chest injuries or surgeries**

If YES, when and what: \_\_\_\_\_

If YES, any permanent breathing problems: \_\_\_\_\_



**Any other lung problem that you've been told about**

If YES, what: \_\_\_\_\_



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



**Shortness of breath**

If YES, when: \_\_\_\_\_



**Shortness of breath when walking fast on level ground or walking up a slight hill or incline**

If YES, could you wear a respirator while walking in this fashion? \_\_\_\_\_



**Shortness of breath when walking with other people at an ordinary pace on level ground**



**Have to stop for breath when walking at your own pace on level ground**



**Shortness of breath when washing or dressing yourself**



**Shortness of breath that interferes with your job**



**Coughing that produces phlegm (thick sputum)**

If YES, what makes you cough: \_\_\_\_\_



**Coughing that wakes you early in the morning**



**Coughing that occurs mostly when you are lying down**

If YES, can you breathe easily lying completely flat? \_\_\_\_\_



**Coughing up blood in the last month**

If YES, what was the cause: \_\_\_\_\_

If YES, does it continue? \_\_\_\_\_



**Wheezing**

If YES, what triggers wheezing: \_\_\_\_\_

If YES, how is your wheezing treated: \_\_\_\_\_

If YES, what activities can you not do because of wheezing: \_\_\_\_\_



**Wheezing that interferes with your job**



**Chest pain when you breathe deeply**



**Any other symptoms that you think may be related to lung problems**

If YES, what: \_\_\_\_\_



5. Have you ever *had* any of the following cardiovascular or heart problems?



**Heart attack**

If YES, when: \_\_\_\_\_

If YES, how was it treated: \_\_\_\_\_

If YES, do you have ANY limitations as a result of your heart attack: \_\_\_\_\_



**Stroke**

If YES, when: \_\_\_\_\_

If YES, how was your stroke treated: \_\_\_\_\_

If YES, do you have ANY limitations as a result of your stroke: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

YES

NO

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>Angina (heart pain)</b><br/>If YES, when: _____<br/>If YES, how was your angina treated: _____<br/>If YES, do you still get angina: _____</p>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>Heart failure</b><br/>If YES, when: _____<br/>If YES, how was your heart failure treated: _____<br/>If YES, do you have ANY limitations as a result of heart failure: _____</p>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>Swelling in your legs or feet (not caused by walking)</b><br/>If YES, does your swelling limit your activity in ANY way: _____</p>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>Heart arrhythmia (heart beating irregularly)</b><br/>If YES, what was the rhythm: _____<br/>If YES, how was the rhythm treated: _____<br/>If YES, does an arrhythmia continue to limit your activity in ANY way: _____</p>                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>High blood pressure</b><br/>If YES, is your blood pressure treated and controlled: _____</p>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>Any other heart problem that you've been told about</b><br/>If YES, describe: _____</p>   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you <i>ever had</i> any of the following cardiovascular or heart symptoms?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>Frequent pain or tightness in your chest</b><br/>If YES, when: _____<br/>If YES, how was your pain medically evaluated: _____<br/>If YES, does it limit your activity in ANY way: _____</p>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>Pain or tightness in your chest during physical activity</b><br/>If YES, what activity gives you chest pain: _____</p>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>Pain or tightness in your chest that interferes with your job</b></p>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>In the past two years, have you noticed your heart skipping or missing a beat</b><br/>If YES, how was this medically evaluated: _____<br/>If YES, how was this treated: _____<br/>If YES, does it limit your activity in ANY way: _____</p> |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>Heartburn or indigestion that is not related to eating</b><br/>If YES, what caused your heartburn or indigestion: _____<br/>If YES, does this condition limit your activity in ANY way: _____</p>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>Any other symptom that you think may be related to heart or circulation problems</b><br/>If YES, describe: _____</p>  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you <i>currently</i> take medication for any of the following problems?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>Breathing or lung problems</b><br/>If YES, what is the problem: _____<br/>If YES, how is the problem controlled: _____<br/>If YES, does this limit your activity in ANY way: _____</p>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>Heart trouble</b><br/>If YES, what is your heart trouble: _____<br/>If YES, how is your heart trouble treated: _____<br/>If YES, does your heart trouble limit your activity in ANY way: _____</p>  |

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

YES

NO

- Blood pressure**  
If YES, does your blood pressure OR your blood pressure medicine limit your activity in ANY way: \_\_\_\_\_
- Seizures (fits)**  
If YES, when was your last seizure: \_\_\_\_\_  
If YES, does your seizure disorder OR seizure medicine limit your activity in ANY way: \_\_\_\_\_
8. If you've used a respirator, have you *ever had* any of the following problems?
- Eye irritation**  
If YES, did it limit your respirator use in ANY way: \_\_\_\_\_
- Skin allergies or rashes**  
If YES, did it limit your respirator use in ANY way: \_\_\_\_\_
- Anxiety**  
If YES, did it limit your respirator use in ANY way: \_\_\_\_\_
- General Weakness or fatigue**  
If YES, did it limit your respirator use in ANY way: \_\_\_\_\_
- Any other problem that interferes with your use of a respirator**  
If YES, describe: \_\_\_\_\_
9. Would you like to talk to the health care professional who will review this questionnaire about your answers?

**Questions 10 to 15 below must be answered by every employee who has been selected to use either a full face-piece 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)?  
If YES, describe: \_\_\_\_\_
11. Do you *currently* have any of the following vision problems?
- Wear contact lenses**
- Wear glasses**
- Color blind**
- Any other eye or vision problem?**  
If YES, describe: \_\_\_\_\_
12. Have you *ever* had an injury to your ears, including a broken ear drum?  
If YES, describe: \_\_\_\_\_
13. Do you *currently* have any of the following hearing problems?
- Difficulty hearing?**  
If YES, describe: \_\_\_\_\_
- Wear a hearing aid?**  
If YES, describe: \_\_\_\_\_
- Any other hearing or ear problem?**  
If YES, describe: \_\_\_\_\_
14. **Have you *ever* had a back injury?**  
If YES, describe: \_\_\_\_\_

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YES

NO

- 15. Do you currently have any of the following musculoskeletal problems?
Weakness in any of your arms, hands, legs or feet?
Back pain?
Difficulty fully moving your arms or legs?
Pain or stiffness when you lean forward or backward at the waist?
Difficulty fully moving your head up or down?
Difficulty fully moving your head side to side?
Difficulty bending at your knees?
Difficulty squatting to the ground?
Climbing a flight of stairs or a ladder carrying more than 25 lbs.?
Any other muscle or skeletal problem that interferes with using a respirator?

I have read and understand the above information and certify that the answers are true and complete to the best of my knowledge.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical

Comments on history: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Occupational Health Staff (if indicated) \_\_\_\_\_ Date \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_



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Vital Signs: BP \_\_\_\_\_ HR \_\_\_\_\_ RR \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Physical Examination: (if indicated)

	N	A	O	Comments
1. ENT				
2. Heart				
3. Lungs				

Reviewed By:

Provider Signature

Date

- John Kipp, MD
- Kevin Wall, MD
- Jennifer Ring, OHN

- Evelyn Nietfeld, CNP
- Kevin O'Connell, MD
- Other \_\_\_\_\_

- Michelle Manos, PA
- William Isaksen, MD

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_