APPENDIX E

RESPIRATOR MEDICAL EVALUATION FORM

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 this questionnaire alone. In some cases we may ask for more information or additional medical testing/evaluation. Fit testing is also required and is done separately. All medical information is considered confidential.

All Information Must Be Completed For Respirator Approval

Date _____

Name_____Age_____Employee # _____

Location_____Work Phone_____

1. When using respirator, work is	☐ Light	☐ Moderate	☐ Heavy
2. Shifts per week respirator is worn	☐ <1	☐ 1-4	☐ Almost every
3. Length of time respirator is worn	☐ <1 hour	☐ 1-5 hours	☐ 5-12 Hours

Medical History

Has a doctor ever told you that you have any of the following?

1. Angina	☐ Yes	☐ No
2. Heart Attack	☐ Yes	☐ No
3. Heart Disease	☐ Yes	☐ No
4. Epilepsy or Seizures	☐ Yes	☐ No
5. High Blood Pressure	☐ Yes	☐ No
6. Diabetes Treated w/Insulin	☐ Yes	☐ No
7. Lung Disease	☐ Yes	☐ No
8. Emphysema	☐ Yes	☐ No
9. Asthma	☐ Yes	☐ No
	☐	☐

10. Are you allergic to natural rubber latex? ☐ Yes ☐ No

Explain any "Yes" answers by number.

_____

11. Smoking History ☐ Smoker ☐ Ex-Smoker ☐ Never Smoked

12. Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list _____

Review of Systems

13. Are you short of breath at rest? ☐ Yes ☐ No

14. Do you get short of breath when walking? ☐ Yes ☐ No

15. Do you get short of breath at work? ☐ Yes ☐ No

16. Do you get chest pain with certain activities? ☐ Yes ☐ No

17. Do you get chest pain at work? ☐ Yes ☐ No

18. Do you have medical problems that might interfere with respirator use? ☐ Yes ☐ No

19. Have you ever had problems wearing a respirator? ☐ Yes ☐ No

Explain any "Yes" answers by number.

_____

Employee's Signature_____Date _____

Physician Use Only

☐ Approved ☐ Approved with Restrictions ☐ Denied

☐ More Information Needed, Please Specify _____

Restriction Remarks_____

_____

Physician's Signature_____Date _____