SCL Health

Associate Occupational Health Services

Medical Respiratory Evaluation Questionnaire

□ Baseline □ Annual

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Today's Date: _____ Sex: M F

Name (please print):_____ Department _____

Associate #: _____ Job Title: _____

Soc. Security # (last 4): _____ □ GSMC □ LMC □ SJH □ SCLP

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

_____

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Medical Respirator Evaluation Questionnaire:

1. Has your employer told you how to contact the health care professional who will review this questionnaire? □ Yes □ No
2. Check the type of respirator you will use (you can check more than one category):
   a. N., R. or P. disposable respirator (filter – mask, non-cartridge type only).
   b. Other type (for example, half or full faced piece type, powered air purifying, supplied air, self-contained breathing apparatus).
3. Have you worn a respirator before? □ Yes □ No If yes, what type(s): _____

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 symptoms of 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 ribs: Yes No
   k. Any chest injuries or surgeries: Yes No
   l. Any other lung problem 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 beating 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 symptoms 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 never used a respirator, check the following space _____ and go to question 9)
   If you've used a respirator, have you *ever had* any of the following problems?
   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 wish to discuss any of the above with the medical practitioner (RN or MD)? Yes No

Medically reviewed by

_____ Date _____