



**SKAGIT VALLEY OCCUPATIONAL MEDICINE**  
**1400 East Kincaid Street Mount Vernon**  
**Medical Questionnaire for Respirator Users**

Part A Section 1 (Mandatory)

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

Age: \_\_\_\_ (yr) Male \_\_\_\_ Female \_\_\_\_ Height: \_\_Ft.\_\_in. Weight: \_\_\_\_

Employer: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Phone number where licensed health care provider can contact you: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Best times to reach you: \_\_\_\_\_

Has your employer told you how to contact the health care professional who will review this questionnaire? \_\_\_\_ YES \_\_\_\_ NO

Check the type of respirator you will use (more than one category can be checked).

- a. \_\_\_\_ N, R or P disposable respirator (filter mask type, not cartridge type)
- b. \_\_\_\_ Other type (half-mask, full face piece, powered air purifying or supplied air)
- c. \_\_\_\_ SCBA (Self-Contained Breathing Apparatus)

Have you worn a respirator before? \_\_\_\_ YES \_\_\_\_ NO

If yes, what type? \_\_\_\_\_

Part A Section 2 (Mandatory)

All the below questions must be answered yes or no by anyone selected to wear any type of respirator.

#	QUESTIONS	YES	NO
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		
	C Allergic reactions that interfere with your breathing		
	D Claustrophobia (fear of closed 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 Pneumothorax (collapsed lung)		
	I Lung cancer		
	J Broken ribs		
	K Any chest injuries or surgeries		
	L Any other lung problems that you have been told about?		
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 a 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 up early in the morning		
	I Coughing that occurs mostly when you are laying down		

	J Coughing up blood in the last month		
	K Wheezing		
	L Wheezing that interferes with your job		
	M Chest pain when you breath deeply		
	N Any other symptom 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 (irregular heart beat)		
	G High blood pressure		
	H Any other heart problem that you've been told about?		
6	Have you ever had any of the following cardiovascular or health 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 two 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		
8	If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check both boxes (yes and no) and go on to question 9.		
	A Eye irritation		
	B Skin allergies or rashes		
	C Anxiety		
	D General weakness or fatigue		
	E Any other problems that interfere with respirator use?		
9	Would you like to talk to a health care professional who will review this questionnaire about your answers to the questionnaire?		

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.

#	QUESTION	YES	NO
10	Have you ever lost vision in either eye (temporarily or permanently)		
11	Do you currently have any of these following vision problems		
	A Wear contact lenses		
	B Wear glasses		
	C Color blind		
	D Any other vision problems?		
12	Have you ever had an injury to your ears, including a broken eardrum?		
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 problems?		
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 side to side		
	F Difficulty fully moving your head up or down		
	G Difficulty bending at your knees		
	H difficulty squatting to the ground		
	I Climbing a flight of stair or a ladder carrying more than 25 pounds		
	J Any other muscle or skeletal problem that interferes with using a respirator?		

Part B

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

#	QUESTION	YES	NO
1	In your present job, are you working at high altitudes (over 5,000 ft) 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 (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 material, or under any of the conditions listed below?		
	A Asbestos		
	B Silica (sandblasting)		
	C Tungsten/cobalt(grinding or welding this material)		
	D Beryllium		
	E Aluminum		
	F Coal (mining)		
	G Iron		
	H Tin		
	I Dusty environments		
	J Any other hazardous exposures?		
	K If yes to any of the above, describe these exposures		
4	List any second jobs or side businesses you may have		
5	List your previous occupations		
6	List your current and present hobbies		
7	Have you been in the military services?		
	If yes, were you exposed to biological or chemical agents (either in training or 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:		
10	Will you be using any of the following items with your respirators?		
	A HEPA filters		
	B Canisters (for example, gas masks)		
	C Cartridges		
11	How often are you expected to use respirators?		
	A For 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 (examples: sitting while writing, standing at the drill press)		
	If yes, how many hours _____ Minutes _____		
	B Moderate (examples: nailing, driving a truck in urban traffic, transferring loads up to 35 pounds at trunk level)		
	If yes, how many hours _____ Minutes _____		
	C Heavy (working on a loading dock, lifting 50 lbs or more from floor to shoulder, shoveling, standing while bricklaying)		
	If yes, how may hours _____ Minutes _____		
13	Will you be wearing protective clothing or equipment when wearing the respirator?		
	If yes, describe the equipment:		
14	Will you be working under hot conditions (greater than 77 degrees)		
15	Will you be working under humid conditions?		
16	Describe the work you will be doing while your are using your respirator(s)		
17	Describe any special hazardous conditions you might encounter when you are using your respirator(s). (for example, confined spaces, life threatening gases)		
18	Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you are using your respirator		
	Name of the first substance: _____ Estimated exposure level per shift: _____ Duration of exposure: _____ Name of the second substance: _____ Estimated exposure level per shift: _____ Duration of exposure: _____		
	The name of any other toxic substances that you will be exposed to while using your respirator(s).		
19	Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others (for example: rescue, safety, security)		

\_\_\_\_\_  
Signature of employee

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Date

Skagit Valley Medical Center  
803 S 15<sup>th</sup> Street  
Mount Vernon, WA 98274

RESPIRATORY QUESTIONNAIRE CLEARANCE REPORT

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Name: \_\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Employer: \_\_\_\_\_ Dept: \_\_\_\_\_

Job Title: \_\_\_\_\_ Date of exam: \_\_\_\_\_

Type of respirator this individual is medically cleared to use:

Check all that apply:

- Half Mask                       Full face piece mask     Helmet hood     Escape  
 Non-powered cartridge or canister     Powered air-purifying cartridge respirator (PAPR)  
 Supplied-Air or Air-line                       disposable filtering face piece (for example, N-95)  
 Self-contained breathing apparatus (SCBA)     Demand or Pressure Demand

Respirator Clearance

Under the conditions described in the supplemental information provided by the employer, this individual (Please check one)

- Is medically cleared for use of the respirator(s) without limitations  
 Is medically cleared for use of the respirator(s) with the following limitations:

\_\_\_\_\_

Is **not medically cleared** for use of respirator.

Workload Limitations:

- Unrestricted     Heavy     Medium     Light

Follow-up Medical Evaluation:

This individual will/will not (circle one) require additional follow-up medical evaluation(s). The recommended schedule for follow-up medical evaluations, if necessary, is as follows:

\_\_\_\_\_

Employee Notification:

I certify that the above-named individual for whom this respirator clearance is provided has received a copy of this recommendation.

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

(Physician or other Licensed Health Care Professional)

## INSTRUCTIONS FOR COMPLETION OF RESPIRATORY MEDICAL CLEARANCE

1. In order to receive a Respirator Medical Clearance you must complete this entire form. If you have any questions regarding the completion of this form, and it is not covered below, please contact either Safety or Human Resources.
2. **Once you have completed this form, return it to Safety or Human Resources (in a sealed envelope) for submission and review.** The review is done by a Licensed Health Care Professional at **Skagit Valley Occupational Medicine**, 1400 East Kincaid Street, Mt. Vernon, WA. **360.848.4150**, and any results will be made known to you immediately. If, while you are completing the form, questions arise, please mark that area of the questionnaire with an "X", which signifies an interest in further discussion with a health care provider, or call Skagit Valley Occupational Medicine directly at the number above.
3. 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.
4. Please print legibly, answering all the questions to the best of your ability. If you don't understand or know the answer to a question, leave it blank.
5. The last page, "**Respiratory Questionnaire Clearance Report**" is to be left blank, except for filling in your Name, SSN, Employer, Dept., and Job Title. This document will then be used by the doctor to report your results to you.