Island Occupational Medical Resources, P.C.

618 Broadway, Amityville, New York 11701
T-516.691.6000 | F-516.797.1826

www.iomr.net

125 - MEDICAL QUESTIONNAIRE FOR RESPIRATOR USE

Last Name:	First Name:		
Patient ID:	DOB:	Sex:	MR#:
Company Name:		Company ID:	

PHYSICAL REQUIREMENTS:

Are there any specific physical demands of the job that are important? (example: lifting, carrying) Yes ☐ No ☐
If yes, please specify:

_____

PROTECTIVE EQUIPMENT:

Is clearance for the use of respiratory protective equipment needed? Yes ☐ No ☐

Escape only (no rescue) ☐ Emergency rescue only ☐

Is there specific safety equipment (beyond hard hat, gloves, boots, and appropriate clothing) that are used in the safe performance on the job? If yes please specify: Yes ☐ No ☐

_____

1. THIS EMPLOYEE USES THE FOLLOWING TYPES OF RESPIRATORY PROTECTIVE EQUIPMENT:

		DURATION	FREQUENCY	TEMPERATURE EXTREMES	HUMIDITY
	HALF FACE PIECE AIR PURIFYING RESPIRATOR				
	FULL FACE PIECE AIR PURIFYING RESPIRATOR				
	POWERED AIR PURYING RESPIRATOR				
	SELF-CONTAINED BREATHING APPARATUS				
	AIR LINE RESPIRATOR				

2. Is it possible that this individual will be required to wear Level A protection at any time? [SCBA, fully encapsulated suit, chemical resistant gloves & boots] Yes ☐ No ☐

3. Is it possible that this individual will be required to wear Level B protection at any time? [SCBA, chemical resistant clothing, chemical resistant gloves & boots] Yes ☐ No ☐

_____

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4. During the period you are using the respirator(s), is your work effort:

   a. **Light** (less than 200 kcal per hour) Yes ☐ No ☐ How long _____ hrs per shift

   b. **Moderate** (200 to 359 kcal per hour) Yes ☐ No ☐ How long _____ hrs per shift
   Examples: sitting while mailing or filing: driving a truck or transferring a moderate load (about 35 lbs.) At trunk level; walking on a level surface about 2 mph

   c. **Heavy** (above 350 kcal per hour) Yes ☐ No ☐ How long _____ hrs per shift
   Examples: lifting a heavy load (about 50 lbs) from the floor to your waist; working on a loading dock; Shoveling; standing while bricklaying; climbing stairs with a heavy load (about 50 lbs)

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

_____

6. Are there any substances which you can not work with? List:

_____

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TOXIC EXPOSURE HISTORY

At work or at home have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, dust) or have you come to skin contact with hazardous chemicals?
List:

_____

Have you worked with any of the materials, or under any of the conditions, listed below:

	Yes	No
Asbestos	☐	☐
Silica (e.g., sandblasting	☐	☐
Coal (e.g., mining).	☐	☐
Grinding	☐	☐
Welding	☐	☐
Aerosols	☐	☐
Asphalt, pitch or tar	☐	☐
Beryllium	☐	☐
Cadmium	☐	☐
Cotton Dust	☐	☐
Pesticides	☐	☐
Fuel Specify: _____	☐	☐
Oils	☐	☐
Lead	☐	☐
Nickel/Chrome	☐	☐
Paint	☐	☐
Microwave/Radio Frequency	☐	☐
Nuclear Radiation/X-Ray	☐	☐
Fiberglass	☐	☐
Plastics	☐	☐
Solvents	☐	☐
Compressed Gases	☐	☐
Aluminum	☐	☐
Iron	☐	☐
Tin	☐	☐
Dusty Environments	☐	☐

	Yes	No
Have you ever worked around vibration or with vibrating tools?	☐	☐
Have you ever worked in a doctor's office, clinic or hospital where you might have had exposure to –biohazardous materials?	☐	☐
Have you ever performed a site assessment on any of the above industry groups or materials? Please list:	☐	☐
Any other hazardous exposures? If "yes", describe these exposures:	☐	☐
Have you ever lived near large industrial plants or a air pollution?	☐	☐
Have you ever received hazardous duty or environmental pay?	☐	☐
Have you ever been in the military service? If "yes" were you exposed to biological or chemical agents (either in training or combat?)	☐	☐
Have you ever worked on a HAZMAT team?	☐	☐
List any second jobs or side businesses you have:		
List your current and previous hobbies:		

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RESPIRATOR USERS ONLY

THE FOLLOWING 2 PAGES ONLY NEED TO BE COMPLETED BY THOSE ASSIGNED TO USE RESPIRATORS.
IF UNCERTAIN ABOUT RESPIRATOR USE, PLEASE COMPLETE

RESPIRATOR USE	Yes	No
1. Have you ever worn a respirator in the past? If no, go to question 4.	☐	☐
2. What type of respirator did you wear? Mark all that apply: ☐ Disposable particulate filter mask (non-cartridge dust masks) ☐ Half face cartridge respirator ☐ Full face cartridge respirator ☐ Powered air purifying respirator ☐ Supplied air (airline) respirator ☐ Escape only respirator		
3. If you have ever used a respirator, have you ever had any of the following problems?		
Eye Irritation	☐	☐
Skin allergies or rashes	☐	☐
Anxiety	☐	☐
General weakness or fatigue	☐	☐
Any other problem or difficulty that interfered with your use of a respirator?	☐	☐

HEART, LUNGS & OTHER BODY SYSTEMS	Yes	No
4. Have you ever had an abnormal EKG? If yes, explain:	☐	☐
5. Have you ever had any of the following cardiovascular or heart problems?		
Heart attack	☐	☐
Stroke	☐	☐
Angina (chest pain)	☐	☐
Heart failure	☐	☐
High blood pressure	☐	☐
Swelling in your legs or feet (not caused by standing or walking)	☐	☐
Swelling in your legs or feet (not caused by standing or walking)	☐	☐
Any other heart problem that you have been told about	☐	☐
6. Have you ever had surgery of the arteries, coronary bypass or angioplasty (to correct blocked artery or aneurysm)? Mark only one answer: ☐ Yes, within the past year ☐ Yes, more than one year ago ☐ No		

HEART, LUNGS & OTHER BODY SYSTEMS cont.	Yes	No
7. Have you ever had any of the following pulmonary or lung problems?		
Asthma	☐	☐
Chronic bronchitis	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Silicosis	☐	☐
Lung cancer	☐	☐
Broken ribs	☐	☐
Pneumothorax (collapsed lung)	☐	☐
Any chest injuries or surgeries	☐	☐
8. Have you ever had seizures (fits)?	☐	☐
9. Have you ever been told you had diabetes?	☐	☐
10. Have you ever had allergic reactions that interfere with your breathing?	☐	☐
11. Have you ever experienced claustrophobia (fear of closed in places)?	☐	☐
12. Have you ever had trouble smelling odors?	☐	☐
13. Have you ever had any of the following pulmonary, cardiovascular, lung or heart symptoms?		
Shortness of breath	☐	☐
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
Have to stop for breath when walking or dressing yourself	☐	☐
Shortness of breath that interferes with your job	☐	☐
14. Do you currently take medication for any of the following problems?		
Breathing	☐	☐
Heart trouble	☐	☐
Blood pressure	☐	☐
Seizure (fits)	☐	☐
15. Have you within the past had any of the following symptoms of lung illness?		
Coughing that produces phlegm (thick sputum)	☐	☐
Coughing that occurs mostly when lying down	☐	☐
Coughing up blood in the last month	☐	☐
Wheezing	☐	☐
Wheezing that interferes with your job	☐	☐
Chest Pain when you breath	☐	☐
Coughing that wakes you early in the morning	☐	☐
Any other symptons that may be related to lung issue	☐	☐

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HEART, LUNGS & OTHER BODY SYSTEMS cont.	Yes	No
16. Have you ever had any of the following cardiovascular or heart symptoms?		
Frequent pain or tightness in your chest	☐	☐
Pain or tightness in chest during physical activity	☐	☐
Pain or tightness in chest that interferes with job	☐	☐
In the past two years, is your heart skipping or missing a beat?	☐	☐
Heartburn or indigestion that is not related to eating	☐	☐
Any other symptoms that you think might be related to hear or circulation problems	☐	☐
FULL FACE OR SCBA-RESPIRATOR USER ONLY		
The following questions must be answered by every employee who has been selected to use either a full-face piece respirator or Air Supply Respirator (Self-contained Breathing Apparatus (SCBA) or air line)		
	Yes	No
17. Have you ever lost vision in either eye (temporarily or permanently)?	☐	☐
18. Do you currently have any of the following vision problems?		
Wear contact lenses	☐	☐
Wear glasses	☐	☐
Color blind	☐	☐
Any other eye or vision problems	☐	☐
19. Have you ever had an injury to your ears, including a broken ear drum?	☐	☐
20. Do you currently have any of the following hearing problems?		
Difficulty hearing	☐	☐
Wear a hearing aid	☐	☐
Any other hearing or ear problem	☐	☐
Explain:		

FULL FACE OR SCBA-RESPIRATOR USER ONLY cont.	Yes	No
21. Have you ever had a back injury?	☐	☐
22. Do you currently have any of the following muscle or skeletal problems?		
Weakness in any of your arms, hands, legs or feet	☐	☐
Back pain	☐	☐
Difficulty fully moving your arms and legs	☐	☐
Pain or stiffness when you lean forward or backward at the waist	☐	☐
Difficulty fully moving your head up/down	☐	☐
Difficulty fully moving your head side/side	☐	☐
Difficulty bending at your knees	☐	☐
Difficulty squatting to the ground	☐	☐
Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐	☐
Any other muscle or skeletal problems that might interfere with using a respirator? Explain:		

Patient Signature _____ Date _____

Reviewed by:

Practitioner Signature _____ _____

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