Respirator Medical Evaluation Protocol Questionnaire

Part A. Section 1- Basic Demographics

1. Employee Name: _____
2. Employer: _____ Job Title: _____
3. Address: _____ County: _____
4. Respirator Type Selected: _____ Manufacturer: _____
5. Model: _____ Size: _____

Part A. Section 2

Have you ever used a respirator? _____yes _____no; if so, what kind? _____

1. Has respirator use caused any of the following?
   - **a.** Eye irritation
   - **b.** Skin allergies-
   - **c.** Anxiety, Choking, Hyperventilation
   - **d.** General weakness or fatigue
   - **e.** Any other problem that interferes with your respirator use
2. Do you currently smoke tobacco or have you ever smoked? _____yes ____no

   Number of years smoked: _____

   Number of packs of cigarettes smoked per day _____

Have you ever had any of the following conditions?

3. Seizures?
   a. Within the last two years? ___Yes ___No
   b. Are you currently under the care of a MD for your seizures? ___Yes ___No
   c. Are your seizures under control? ___Yes ___No

4. Diabetes (Sugar Disease)?

a. Are you currently under the care of MD for diabetes? ___Yes ___No
b. Is your diabetes under control? ___Yes ___No

c. How do you control your diabetes?
    a. Diet
    b. Oral Medication
    c. Insulin

Allergic reactions that interfere with your breathing? ___Yes ___No

Claustrophobia (fear of closed-in places)?

a. Does wearing a respirator cause your claustrophobia? Trouble smelling odors?

Unexplained loss of consciousness?

a. Within the last two years? ___Yes ___No
b. Greater than two years? ___Yes ___No

Have you ever had any of the following pulmonary or lung problems?

Asbestosis? ___Yes ___No

Asthma? ___Yes ___No

a. Treated within the last two years? ___Yes ___No
b. Are you currently taking any Asthma medication? ___Yes ___No
c. Chronic bronchitis? ___Yes ___No

Emphysema? ___Yes ___No

Pneumonia? ___Yes ___No

Are you currently receiving treatment for pneumonia? ___Yes ___No

a. Has it been resolved?

Tuberculosis? ___Yes NO

a. Have you received treatment?
b. Has it been resolved?

16. Silicosis: ___Yes ___No

17. Pneumothorax (collapsed lung)? ___Yes ___No

a. Have you received treatment? ___Yes ___No
b. Has it been resolved? ___Yes ___No

18. Lung Cancer? Broken Ribs? ___Yes ___No

Have you received treatment? ___Yes ___No

Has it been resolved? ___Yes ___No

Any chest injuries or surgeries? ___Yes ___No

a. Have you received treatment? ___Yes ___No
b. Has it been resolved- If yes- Proceed to fit testing? ___Yes ___No

Any other lung problems that you are aware of?

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

23. Shortness of breath?
24. Shortness of breath when walking fast on level ground or walking up a slight hill or incline?
25. Shortness of breath when walking with other people at an ordinary pace on level ground
26. Have to stop for breath when walking at your own pace on level ground?
27. Shortness of breath when washing or dressing yourself?
28. Shortness of breath that interferes with your job?
29. Persistent cough (most days for three or more months per year)?
30. Coughing that produces phlegm (thick sputum)?
31. Persistent phlegm (most days for three or more months per year)?
32. Coughing that wakes you early in the morning?
33. Coughing that occurs mostly when you are lying down?
34. Coughing up blood in the last month?
35. Wheezing?
36. Wheezing that interferes with your job?
37. Chest pain when you breathe deeply? Any other symptoms that you think may be related to lung problems?

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

38. Heart attack?
    a. What was the date of your heart attack?
39. Stroke?
    a. If yes, has your MD medically cleared you to perform a job requiring a respirator?
40. Angina (chest pain)
41. Heart failure
42. Swelling in your legs or feet (not caused by walking)
43. Heart arrhythmia (heart beating irregularly or very fast)?
44. High blood pressure
    a. Are you under the care of MD for high blood pressure?
    b. Is your blood pressure under control with medication?

45. Any other heart problems that you are aware of?

Have you ever had any of the following cardiovascular or heart symptoms?

46. Frequent pain or tightness in your chest?
    a. Within the last two years?
47. Pain or tightness in your chest during physical activity?
    a. Within the last two years?
48. Pain or tightness in your chest that interferes with your job?
    a. Within the last two years?
49. In the past two years, have you noticed your heart skipping or missing a beat?
    a. Have you seen a MD for this condition?
    b. Has your MD medically cleared you to perform a job requiring a respirator?
50. Heartburn or indigestion that is not related to eating?
    a. Within the last two years
51. Any other symptoms that you think may be related to heart or circulation problems (describe)

Do you currently take medication for any of the following?

47. Breathing or lung problems
48. Heart Trouble
49. Blood Pressure
50. Seizures (Fits)
51. Diabetes (shot or pill)

Miscellaneous

52. Have you seen a doctor in the last year for a medical problem?
53. Have you ever lost vision in either eye?
    a. Was it permanent?

54. Do you currently have any of the following vision problems?
    a. Wear contact lens?
    b. Wear glasses?
    c. Are you required to wear glasses while wearing a respirator?
    d. Color blind?
55. Any other eye or vision problem?
56. Have you ever had an injury to your ears, including a broken ear drum?
57. Is your ear drum still currently ruptured
58. Do you currently have any of the following hearing problems?

59. Difficulty hearing?
60. Wear a hearing aid?
61. Any other hearing or ear problem?
62. Have you ever had a back injury?
    a. Does this currently make use of a respirator difficult?

Do you currently have any of the following musculoskeletal problems?

63. Weakness in any of your arms, hands, legs, or feet?
    a. Does this currently make use of a respirator difficult?
64. Back pain?
    a. Does this currently make use of a respirator difficult?
65. Difficulty fully moving your arms and legs?
    a. Does this currently make use of a respirator difficult?
66. Pain or stiffness when you lean forward or backward at the waist?
    a. Does this currently make use of a respirator difficult?
67. Difficulty fully moving your head up or down?
    a. Does this currently make use of a respirator difficult?
68. Difficulty moving your head side to side?
    a. Does this currently make use of a respirator difficult?
69. Difficulty bending at your knees?
    a. Does this currently make use of a respirator difficult?
70. Difficulty squatting to the ground?
    a. Does this currently make use of a respirator difficult?
71. Climbing a flight of stairs or a ladder carrying more than 25 pounds.
    a. Does this currently make wearing a respirator difficult?
72. Any other muscle or skeletal problem that interferes with using a respirator?

Reviewed by AgriSafe-NC Nurse Coordinator and NC Agromedicine Institute Medical Director:

AgriSafe-NC Nurse Coordinator	Date	Medical Director	Date