



BASELINE MEDICAL QUESTIONNAIRE FOR RESPIRATORY CLEARANCE

Date: _____ Visit Type: _____
Patient Name: _____ Company Name: _____
Patient Address: _____ Company Address: _____

DOB: _____ Company Contact: _____
Patient SS#: _____ Sex: _____ Company Phone #: _____
Phone #: _____

Part A – Section 1

1. Type of respirator you will use (check all that apply :)
 N, R, or P disposable respirator (filter-mask Non-cartridge type only)
 Other type (half or full-face piece type, powered-air purifying, supplied air, self contained breathing apparatus.)
2. Have you worn a respirator? Yes No
If yes, what types? _____
Place of Birth: _____
Job Title: _____

Part A – Section 2

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 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 Yes No
i. Lung Cancer Yes No
j. Broken ribs Yes No
k. Chest injuries or surgeries Yes No
l. Other lung problem Yes No
3. 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 legs or feet (not caused by walking) Yes No
f. Heart Arrhythmia Yes No
g. High blood Pressure 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 Yes No
-walking up a slight hill Yes No
-walking with others on level ground Yes No
c. Have to stop for breath when walking Yes No
d. Coughing that
-produce phlegm Yes No
-wakes you in the morning Yes No
-occurs when lying down Yes No
-produces blood Yes No
e. Wheezing that interferes with your job Yes No
f. Chest pain when you breathe deep Yes No
g. Symptoms that might be related to lung problems Yes No
5. 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 chest during physical activity Yes No
c. Pain or tightness in 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/indigestion not related to eating Yes No
f. Any other symptoms that you think may be related to heart or circulation problems Yes No
6. 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 Yes No
e. Trouble smelling odors 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. Have you ever used a respirator? Yes No
No – go to question 9
Yes – have you ever had any of the following problems
a. Eye irritation Yes No
b. Skin allergies/rash Yes No
c. Anxiety Yes No
d. General weakness/fatigue Yes No
e. Other problems that interfere with your use of a respirator? Yes No
9. Would you like to talk to the health care professional who will review this questionnaire? Yes No

Patient Signature

BASELINE MEDICAL QUESTIONNAIRE FOR RESPIRATORY CLEARANCE – Page 2

Date: _____ Visit Type: _____
Patient Name: _____ Company Name: _____
Patient Address: _____ Company Address: _____

DOB: _____ Company Contact: _____
Patient SS#: _____ Sex: _____ Company Phone #: _____
Phone #: _____

Questions 10 through 15 must be answered by every employee who wears either a full-face respirator or a self contained breathing apparatus (SCBA)

10. Have you ever lost vision in either eye (temporarily or permanently)? Yes No
11. Do you currently have any of the following visual problems?
a. Wear contact Lenses Yes No
b. Wear glasses Yes No
c. Color blind Yes No
d. Any other eye or vision problems Yes No
12. Have you ever had an injury to your ears, including a broken eardrum? Yes No
13. Do you currently have any of the following hearing problems?
a. Difficulty hearing Yes No
b. Wear a hearing aid Yes No
c. Any other hearing or ear problems Yes No
14. Have you ever had a back injury? Yes No
15. Do you currently have any of the following musculoskeletal problems?
a. Weakness in any of your arms, hands, legs or feet Yes No
b. Back Pain Yes No
c. Difficulty moving your arms and legs Yes No
d. Pain or stiffness when you lean forward or backward at the waist Yes No
e. Difficulty moving your head up or down Yes No
f. Difficulty moving your head side to side Yes No
g. Difficulty bending at your knees Yes No
h. Difficulty squatting to the ground Yes No
i. Difficulty climbing a flight of stairs or a ladder while carrying more than 25 lbs Yes No
j. Any other muscle or skeletal problem that interferes with using a respirator Yes No

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.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?
 Yes No
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?
 Yes No
2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes or dust), or have you come into skin contact with hazardous chemicals?
 Yes No
If yes, names the chemicals if you know them: _____

3. Have you ever worked with any of the materials, or under any of the conditions listed below?
a. Asbestos Yes No
b. Silica (e.g. sandblasting) Yes No
c. Tungsten/cobalt (grinding or welding this material) Yes No
d. Beryllium Yes No
e. Aluminum Yes No
f. Coal Yes No
g. Iron Yes No
h. Tin Yes No
i. Dusty Environments Yes No
j. Any other hazardous exposures Yes No
If yes – describe exposures: _____

4. List any second jobs or side businesses you have: _____

5. List your previous occupations: _____

BASELINE MEDICAL QUESTIONNAIRE FOR RESPIRATORY CLEARANCE-Page 3

Date: _____ Visit Type: _____
Patient Name: _____ Company Name: _____
Patient Address: _____ Company Address: _____

DOB: _____ Company Contact: _____
Patient SS#: _____ Sex: _____ Company Phone #: _____
Phone #: _____

6. List your current and previous hobbies: _____

7. Have you been in the military Services? Yes No
If yes, were you exposed to biological or chemical agents (either in training or combat)? Yes No

8. Have you ever worked on a HAZMAT team? Yes No

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)? Yes No
If yes, name the medications if you know them: _____

10. Will you be using any of the following items with your respirator?

- a. HEPA Filters Yes No
- b. Canisters (e.g. gas masks) Yes No
- c. Cartridges Yes No

11. How often are you expected to use the respirators (s)? Check a response for all that apply.

- a. Escape only (no rescue) Yes No
- b. Emergency rescue only Yes No
- c. Less than 5 hours per week Yes No
- d. Less than 2 hours per day Yes No
- e. 2 to 4 hours per day Yes No
- f. Over 4 hours per day Yes No

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

- a. **Light** (less than 20kcal per hour) Yes No
If "yes", how long does this period last during the average shift: _____ hrs. _____ min.

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1 to 3 lbs.) or controlling machines.

- b. **Moderate** (200 to 350 kcal per hour) Yes No
If "yes", how long does this period last during the average shift: _____ hrs _____ min.

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs) on a level surface.

- c. **Heavy** (above 350 kcal per hour) Yes No
If "yes", how long does this period last during the average shift: _____ hrs _____ min

Examples of heavy work are lifting a heavy load (about 50 lbs) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade at 2 mph; climbing stairs with a heavy load (about 50 lbs).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes No
If yes, describe this protective clothing and/or equipment: _____

14. Will you be working under hot conditions (temperature exceeding 77 degrees Fahrenheit)? Yes No

15. Will you be working under humid conditions? Yes No

BASELINE MEDICAL QUESTIONNAIRE FOR RESPIRATORY CLEARANCE-Page 4

Date:
Patient Name:
Patient Address:

Visit Type:
Company Name:
Company Address:

DOB:
Patient SS#: Sex:
Phone #:

Company Contact:
Company Phone #:

16. Describe the work you'll be doing while you're using your respirator (s): _____

17. Describe any special or hazardous conditions you might encounter when you're 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're using your respirator (s):

Name of Toxic Substance	Estimated Maximum Exposure Level Per Shift	Duration of Exposure Per Shift

List the name of any other toxic substance that you'll be exposed to while using your respirator: _____

19. Describe any special responsibilities you'll have while using your respirator (s) that may affect the safety and well-being of others:
(for example, rescue, security) _____

Patient Signature

Reviewing providers Signature