

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the office of the Surgeon General

REPORT TITLE <p align="center">RESPIRATOR MEDICINE EVALUATION QUESTIONNAIRE</p>	OTSG APPROVED ^(Date) (YYYYMMDD)
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Your employer must allow you to complete 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 and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

PART A SECTION 1 (Mandatory)

Today's date: _____	Height: _____	Weight: _____ lbs
Age:(to nearest yr) _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Best time to phone: _____
Job title: _____	Phone number: _____	

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 (you can check more than one category)

N, R, or P disposable respirator (filter mask, non-cartridge type only)

Other type (for example, half or full facepiece type, powered-airpurifying, supplied-air, self-contained breathing apparatus)

Have you worn a respirator? Yes No If yes, what type(s)? _____

PART A SECTION 2 (Mandatory)

Questions 1 thru 9 below must be answered by every employee who has been selected to use any type of respirator

<p>1. Do you currently smoke tobacco or have you smoked in the past month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever had any of the following conditions:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No a. Seizures (fits)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No b. Diabetes (sugar disease)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No c. Allergic reactions that interfere with your breathing</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No d. Claustrophobia (fear of closed in places)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No e. Trouble smelling odors</p> <p>3. Have you ever had any of the following pulmonary/lung problems?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No a. Asbestosis</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No b. Asthma</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No c. Chronic bronchitis</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No d. Emphysema</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No e. Pneumonia</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No f. Tuberculosis</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No g. Silicosis</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No h. Pneumothorax (collapsed lung)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No i. Lung cancer</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No j. Broken ribs</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No k. Any chest injuries or surgeries</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No l. Any other lung problems that you've been told about</p> <p>4. Do you currently have any of the following symptoms of pulmonary/lung illness?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No a. Shortness of breath</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No b. Shortness of breath when walking fast on level ground or going up a slight hill or incline</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No c. Shortness of breath when walking with other people at an ordinary pace on level ground</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No d. Have to stop for a breath when walking at your own pace on level ground</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No e. Shortness of breath when washing or dressing yourself</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No f. Shortness of breath that interferes with your job</p>
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PREPARED BY (Signature & Date) Nurses signature	DEPARTMENT/SERVICE/CLINIC	Date (YYYYMMDD)
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Patients Identification <i>(For typed or written entries give: Name- Last, First, Middle; grade; date; hospital or medical facility)</i>	<table style="width:100%;"> <tr> <td><input type="checkbox"/> HISTORY/PHYSICAL</td> <td><input type="checkbox"/> FLOW CHART</td> </tr> <tr> <td><input type="checkbox"/> OTHER EXAMINATION OR EVALUATION</td> <td><input type="checkbox"/> OTHER <i>(Specify)</i></td> </tr> <tr> <td><input type="checkbox"/> DIAGNOSTIC STUDIES</td> <td></td> </tr> <tr> <td><input type="checkbox"/> TREATMENT</td> <td></td> </tr> </table>	<input type="checkbox"/> HISTORY/PHYSICAL	<input type="checkbox"/> FLOW CHART	<input type="checkbox"/> OTHER EXAMINATION OR EVALUATION	<input type="checkbox"/> OTHER <i>(Specify)</i>	<input type="checkbox"/> DIAGNOSTIC STUDIES		<input type="checkbox"/> TREATMENT	
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<input type="checkbox"/> OTHER EXAMINATION OR EVALUATION	<input type="checkbox"/> OTHER <i>(Specify)</i>								
<input type="checkbox"/> DIAGNOSTIC STUDIES									
<input type="checkbox"/> TREATMENT									

- 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

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

- Yes No a. Heart attack
- Yes No b. Stroke
- Yes No c. Heart failure
- Yes No d. Angina
- 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

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

- Yes No 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

7. Do you currently take medication for any of the following problems

- Yes No a. Breathing or lung problems
- Yes No b. Heart trouble
- Yes No c. Blood pressure
- Yes No d. Seizures (fits)

8. If you've used a respirator, have you ever had any of the following problems? If you've never used a respirator check the following space and go to question 9

- Yes No 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

9. Would you like to talk to the health care professional who will review this questionnaire about your answers Yes No

10. Have you ever lost vision in either eye Yes No (temporarily or permanently)

11. Do you currently have any of the following vision problems

- Yes No a. Wear contact lenses
- Yes No b. Wear glasses
- Yes No c. Color blind
- Yes No d. Any other eye or vision problems

12. Have you ever had an injury to your ear, Yes No including a broken ear drum

13. Do you currently have any of the following hearing problems

- Yes No a. Difficulty hearing
- Yes No b. Wear a hearing aid
- Yes No c. Any other hearing or ear problems

14. Have you ever had a back injury Yes No

15. Do you currently have any of the following musculoskeletal problems

- Yes No a. Weakness in any of your arms, hands, legs or feet
- Yes No b. Back pain
- Yes No c. Difficulty in fully moving your arms or legs
- Yes No d. Pain or stiffness when you lean forward or backward at the waist
- Yes No e. Difficulty fully moving your head up and down
- Yes No f. Difficulty moving your head fully side to side
- Yes No g. Difficulty bending at your knees
- Yes No h. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs
- Yes No i. any other muscle or skeletal problem that interferes with using a respirator

PART B (IRTD Students only)

BP: _____ Pulse: _____

Resp: _____ Temp: _____

- Yes No Latex allergies?
- Yes No Medication allergies?
- Yes No Any recent health changes or new diagnosis?
- Yes No Under the care of a physician?
- Yes No Hospitalization in the past 6 months?
- Yes No Fever, nausea/vomiting/diarrhea or cough within the past 72 hours?
- Yes No Medications (any medication taken in past 72 hrs to include over the counter drugs)?
- Yes No New prescription in last 2 weeks?
- Yes No Profile or medical restrictions?
- Yes No History of heat/cold injury?
- Yes No Open sores/wounds/sunburn?

PART C

Individuals Signature: _____

- Yes No Reviewed by a licensed health care provider

Provides Signature: _____