1. **Today's date** _____
2. **Student's name** _____
3. **Your age** _____
4. **Sex** _____ **male** _____ **female**
5. **Your height** _____ **feet** _____ **inches**
6. **Your weight** _____ **lbs**

Questions 1 through 15 below MUST be answered – please circle YES or NO

A. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month YES or NO

B. Have you *ever* had any of the following conditions?
- Seizure (fits) YES or NO
- Diabetes (sugar disease) YES or NO
- Allergic reactions that interfere with your breathing YES or NO
- Claustrophobia (fear of closed in places) YES or NO
- Trouble smelling odors YES or NO

C. Have you *ever* had any of the following pulmonary or lung problems?
- Asbestosis YES or NO
- Asthma YES or NO
- Chronic Bronchitis YES or NO
- Emphysema YES or NO
- Pneumonia YES or NO
- Tuberculosis YES or NO
- Silicosis YES or NO
- Pneumothorax (collapsed lung) YES or NO
- Lung cancer YES or NO
- Broken ribs YES or NO
- Any chest injuries or surgeries YES or NO
- Any other lung problem that you have been told about YES or NO

D. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
- Shortness of breath YES or NO
- Shortness of breath when walking up a slight hill or incline YES or NO
- Shortness of breath when walking with other people at an ordinary pace on level ground YES or NO
- Have to stop for breath when walking at your own pace on level ground YES or NO
- Shortness of breath when washing or dressing yourself YES or NO

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
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- Shortness of breath that interferes with your job YES or NO
- Coughing that produces phlegm (thick sputum) YES or NO
- Coughing that wakes you early in the morning YES or NO
- Coughing that occurs mostly when you are lying down YES or NO

- Coughing up blood in the last month YES or NO
- Wheezing YES or NO
- Wheezing that interferes with your job YES or NO
- Chest pain when you breathe deeply YES or NO
- Any other symptoms that you think may be related to lung problems YES or NO

E. Have you *ever* had any of the following cardiovascular or heart problems?
- Heart attack YES or NO
- Stroke YES or NO
- Angina YES or NO
- Heart failure YES or NO
- Swelling in your legs or feet (**not** caused by walking) YES or NO
- Hearth arrhythmia (heart beating irregularly) YES or NO
- High blood pressure YES or NO
- Any other heart problems that you have been told about YES or NO

F. Have you *ever* had any of the following cardiovascular or heart symptoms?
- Frequent pain or tightness in your chest YES or NO
- Pain or tightness in your chest during physical activity YES or NO
- Pain or tightness in your chest that interferes with your job YES or NO
- In the past two years, you have noticed your heart skipping or missing a beat YES or NO
- Heartburn or indigestion that is not related to eating YES or NO
- Any other symptoms that you think may be related to heart or circulation problems YES or NO

G. Do you *currently* take medication for any of the following problems?
- Breathing or lung problems YES or NO
- Heart trouble YES or NO
- Blood pressure YES or NO

H. If you have used a respirator, have you *ever* had any of the following problems?
(If you have never used a respirator, check the following space and go to question #9)
- Eye irritation YES or NO
- Skin allergies or rashes YES or NO
- Anxiety YES or NO
- General weakness or fatigue YES or NO
- Any other problems that interferes with your use of respirator YES or NO

I. Would you like to talk to the health care professional who will review this questionnaire About your answers to this questionnaire? YES or NO

J. Have you *ever* lost vision in either eye (either temporarily or permanently)? YES or NO

K. Do you *currently* have any of the following vision problems?
- Wear contact lenses YES or NO
- Wear glasses YES or NO
- Color blind YES or NO
- Any other eye or vision problems YES or NO

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
PAGE –3-

L. Have you *ever* had any injury to your ears, including a broken eardrum? YES or NO

M. Do you *currently* have any of the following hearing problems?

- Difficulty hearing YES or NO
- Wearing a hearing aid YES or NO
- Any other hearing or ear problems YES or NO

N. Have you *ever* had a back injury? YES or NO

O. Do you *currently* have any of the following musculosketal problems?
- Weakness in any of your arms, hands, legs or feet YES or NO
- Back pain YES or NO
- Difficulty fully moving your arms and legs YES or NO
- Pain or stiffness when you lean forward or backward at the waist YES or NO
- Difficulty moving your head up or down YES or NO
- Difficulty fully moving your head side to side YES or NO
- Difficulty bending at your knees YES or NO
- Difficulty squatting to the ground YES or NO
- Climbing a flight of stairs or a ladder carrying more than 25 lbs. YES or NO
- Any other muscle or skeletal problem that interferes with using a respirator YES or NO

I CERTIFY THAT _____ IS MEDICALLY CLEARED TO USE A HALF FACE OR FULL FACE FRESH AIR RESPIRATOR AND A CARTRIDGE RESPIRATOR.

Doctor Signature_____

Date _____

I GIVE PERMISSION FOR _____ (STUDENT) TO USE A HALF OR FULL FACE FRESH AIR RESPIRATOR AND A CARTRIDGE RESPIRATOR.

Parent/Guardian Signature _____

Date _____