You may contact the ECU Prospective Health professional who will review this questionnaire at (252)744-2070.

East Carolina University

Respirator Medical Evaluation Questionnaire

Can you read? Yes ☐ No ☐

This questionnaire will be sent to the healthcare professional at ECU Prospective Health for review. If the employee is unable to read, an appointment for oral evaluation should be made through ECU Prospective Health.

To maintain your confidentiality, your employer or supervisor must not look or review your answers. Send the completed questionnaire back to ECU Prospective Health through inner campus mail (Mailstop 640) or deliver it to ECU Prospective Health, 188 Warren Life Sciences Building.

PLEASE PRINT ALL ANSWERS.

For every employee who has been selected to use any type of respirator.

Part A. Section 1.

1. Today’s date: ________________________________________________

2. Your name: ________________________________________________

3. Your age (to the nearest year): ________________________________

4. Sex (circle one): Male / Female

5. Your height: _____________ ft. _____________ in.


7. Your job title: ______________________________________________

8. Phone number where you can be reached Mon-Fri from 8:00am-5:00pm by the healthcare professional who reviews this questionnaire (please include area code):
   ________________

9. Check the type of respirator you will use (you can select more than one category):
   a. _____Disposable dust respirator (e.g., filter-mask, non-cartridge type only)
   b. _____Other type (e.g., Half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

10. Have you worn a respirator in the past? Yes ☐ No ☐
    If “yes”, what type(s)?: ________________________________________
Part A. Section 2. (Mandatory)

Questions 1 through 9 below must be answered by any employee who has been selected to use any type of respirator by checking “Yes” or “No”.

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 conditions?
   a. Seizures (fits): Yes ☐ No ☐
   b. Diabetes (sugar disease): Yes ☐ No ☐
   c. Allergic reactions that interfere with your breathing: Yes ☐ No ☐
   d. Claustrophobia (fear of closed-in spaces): Yes ☐ No ☐
   e. Trouble smelling odors: Yes ☐ No ☐

3. 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 (collapsed lung): Yes ☐ No ☐
   i. Lung cancer: Yes ☐ No ☐
   j. Broken ribs: Yes ☐ No ☐
   k. Any chest injuries or surgeries: Yes ☐ No ☐
   l. Any other lung problem(s) that you have been told about: 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 on level ground or walking up a slight hill or incline: Yes ☐ No ☐
   c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes ☐ No ☐
   d. Have to stop for a breath when walking at your own pace on level
ground: 

- Yes □  No □

5. 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 your legs or feet (not caused by walking): 
      - Yes □  No □
   f. Hearth arrhythmia (heart beating irregularly): 
      - Yes □  No □
   g. High blood pressure: 
      - Yes □  No □
   h. Any other heart problem(s) that you have been told about: 
      - Yes □  No □

6. 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 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:  
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

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

If you have never used a respirator, check this box □ and skip to Question 9.

8. If you have used a respirator in the past, have you ever had any of the following problems?  
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(s) that interfere with your use of a respirator:  
Yes  No

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

If you have been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA), answer questions 10-15 below. Others skip to Part B below.

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

11. Do you currently have any of the following vision problems?  
a. Wear contact lenses:  
Yes  No

b. Wear glasses:  
Yes  No

c. Color blind:  
Yes  No

d. Any other eye or vision problem:  
Yes  No

12. Have you ever had an injury to your ears, including a broken ear drum?  
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 problem: 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 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 or down: Yes □  No □
   f. Difficulty fully 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. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes □  No □
   j. Any other muscle or skeletal problem(s) that interfere with using a respirator: Yes □  No □

Part B.

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

2. List any other second jobs or side businesses you have:
   __________________________________________________________
   __________________________________________________________.

3. How often are you expected to use the respirator(s)? Mark “Yes” or “No” 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 □

4. Describe the work you’ll be doing while you’re using your respirator(s):
   __________________________________________________________
   __________________________________________________________.

5. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (e.g., confined spaces, life-threatening gases):
   __________________________________________________________
   __________________________________________________________.
6. 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 ☐

7. Will you be wearing protective clothing and/or equipment (other than respirator) when you are using your respirator?  
   Yes ☐  No ☐

8. Will you be working under hot conditions (temperatures exceeding 77 deg. F)?  
   Yes ☐  No ☐
ECU RESPIRATOR PROTECTION PROGRAM
PROSPECTIVE HEALTH REVIEW:
Employee’s Name (Print)
Cleared ________________________, OK to fit test
Schedule exam ________________________
Employee’s Department
Other ________________________
Employee’s Signature
Signature ________________________
Date ________________________