



# Respirator Medical Evaluation Questionnaire

CCR, TITLE 8, 5144

## To the employee

This questionnaire is only to be distributed to and completed by individuals who are proficient in reading and writing English.

Your supervisor must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. Your supervisor is not permitted to look at or review your answers. To maintain your confidentiality, please send your responses directly to the licensed health care professional listed below. You can e-mail this form, send it via fax, or mail the form directly.

Occupational Health Program Coordinator  
Email: [customerservice@sunrisemedicalcenter.com](mailto:customerservice@sunrisemedicalcenter.com)  
Fax: (714) 771-6918 (confidential fax machine)

Address: Sunrise Medical Center  
Occupational Health Program Coordinator  
867 S. Tustin St.  
Orange, Ca 92866

This evaluation is **mandatory** to help determine your ability to wear a respirator at RSCCD. Your answers will remain confidential. After a review of your responses, the licensed health care professional may in some cases recommend that you receive a physical exam to complete your evaluation. Once you have received medical clearance to wear a respirator, you and the Risk Manager will receive notification of your approval to be fitted for a respirator.

## PART A. SECTION 1. (PLEASE PRINT)

1. Today's date \_\_\_/\_\_\_/\_\_\_/
2. Name \_\_\_\_\_ Employee No. \_\_\_\_\_
3. Your Age \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_
4. Sex  Male  Female
5. Your height \_\_\_\_\_ ft. \_\_\_\_\_ in.      6. Your weight \_\_\_\_\_ lbs.
7. Your Job title \_\_\_\_\_
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code) \_\_\_\_\_ Your e-mail \_\_\_\_\_
9. The best time to phone you at this number \_\_\_\_\_
10. Your Supervisor's Name \_\_\_\_\_
11. Your Supervisor's Phone No. \_\_\_\_\_ Your Supervisor's e-mail \_\_\_\_\_
12. Have you worn a respirator?  No  Yes    If "yes," what type(s) \_\_\_\_\_

**PART A. SECTION 2.**

- |    |   |                             |                              |
|----|---|-----------------------------|------------------------------|
| 1. | Do you currently smoke tobacco, or have you smoked tobacco in the last month?                   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. | Have you ever had any of the following conditions?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | a. Seizures (fits)  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | b. Diabetes (sugar disease)   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | c. Allergic reactions that interfere with your breathing  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | d. Claustrophobia (fear of closed-in places)  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | e. Trouble smelling odors   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. | Have you ever had any of the following pulmonary or lung problems?                              | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | a. Asbestosis   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | b. Asthma   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | c. Chronic bronchitis   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | d. Emphysema  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | e. Pneumonia  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | f. Tuberculosis   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | g. Silicosis  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | h. Pneumothorax (collapsed lung)  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | i. Lung cancer  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | j. Broken ribs  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | k. Any chest injuries or surgeries  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | l. Any other lung problem that you've been told about   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. | Do you <b>currently</b> have any of the following symptoms of pulmonary or lung illness?        | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | a. Shortness of breath  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | c. Shortness of breath when walking with other people at an ordinary pace on level ground       | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | d. Have to stop for breath when walking at your own pace on level ground                        | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | e. Shortness of breath when washing or dressing yourself  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | f. Shortness of breath that interferes with your job  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | g. Coughing that produces phlegm (thick sputum)   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | h. Coughing that wakes you early in the morning   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | i. Coughing that occurs mostly when you are lying down  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | j. Coughing up blood in the last month  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | k. Wheezing   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | l. Wheezing that interferes with your job   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | m. Chest pain when you breathe deeply   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | n. Any other symptoms that you think may be related to lung problems                            | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. | Have you <b>ever had</b> any of the following cardiovascular or heart problems?                 | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | a. Heart attack   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | b. Stroke   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | c. Angina   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | d. Heart failure  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | e. Swelling in your legs or feet (not caused by walking)  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | f. Heart arrhythmia (heart beating irregularly)   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | g. High blood pressure  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | h. Any other heart problem that you've been told about  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. | Have you <b>ever had</b> any of the following cardiovascular or heart symptoms?                 | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | a. Frequent pain or tightness in your chest   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | b. Pain or tightness in your chest during physical activity                                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | c. Pain or tightness in your chest that interferes with your job                                | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | d. In the past two years, have you noticed your heart skipping or missing a beat                | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | e. Heartburn or indigestion that is not related to eating                                       | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|    | f. Any other symptoms that you think may be related to heart or circulation problems            | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

7. Do you **currently** take medication for any of the following problems?
- |                               |                             |                              |
|-------------------------------|-----------------------------|------------------------------|
| a. Breathing or lung problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Heart trouble              | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Blood pressure             | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. Seizures (fits)            | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
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 box and go to question 9)*
- |  |                             |                              |
|--|-----------------------------|------------------------------|
| a. Eye irritation  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Skin allergies or rashes  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Anxiety   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. General weakness or fatigue                                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| e. Any other problem that interferes with your use of a respirator | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire  No  Yes

Please sign your name below indicating the answers you have provided are true and correct to the best of your knowledge.

Signature \_\_\_\_\_



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Santa Ana College • Santiago Canyon College

Occupational Health Program Coordinator  
Sunrise Medical Center  
867 S. Tustin St.  
Orange, Ca  
92866

To Whom it May Concern,

The attached Medical Questionnaire is for an employee who will be using a respirator as part of their job duties while working at our school district.

They may be wearing a typical N-95 mask for general dust/odor control, welding, grinding, or sanding operations. On rarer occasions they may use a half-mask respirator with cartridges and filters for operations such as pesticide application, paint spraying, lead/mold/asbestos inspection or abatement.

Typical usage would be for less than 2 hours per day and less than 4 hours per week.

Their workload would be considered light to moderate while wearing the respirator and they may be wearing safety glasses while using the respirator.

They typically would not be working in hot or humid conditions or other hazardous conditions such as confined spaces. If you have any questions, please let me know.

Sincerely,

Don Maus  
Risk Manager  
714-480-7330  
[Maus\\_donald@rscdd.edu](mailto:Maus_donald@rscdd.edu)



Multispecialist Medical Center

Care Above & Beyond

867 S. Tustin St. · Orange, CA 92866

Phone: (714) 771-1420

Fax: (714) 771-6918

### MEDICAL SERVICES AUTHORIZATION

WEEKDAYS 7 AM - 10 PM

WEEKENDS / HOLIDAYS 9 AM - 5 PM

**OPEN 24/7 FOR WORK RELATED INJURIES, CALL FIRST AFTER HOURS**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> MEDICAL TREATMENT FOR WORK-RELATED INJURY OR ILLNESS | <input type="checkbox"/> PRE-PLACEMENT PHYSICAL | <input type="checkbox"/> DRUG SCREENING                            |
| <input type="checkbox"/> COMMERCIAL DRIVER EXAM                               | <input type="checkbox"/> VACCINE(S): _____      | <input type="checkbox"/> BREATH ALCOHOL TEST                       |
|   | <input type="checkbox"/> TB TEST                | <input checked="" type="checkbox"/> OTHER SERVICES: PLEASE SPECIFY |

EMPLOYEE \_\_\_\_\_ D.O.B. \_\_\_\_\_

EMPLOYER Rancho Santiago Community College district

ADDRESS 2323 N. Broadway, Suite 225

Santa Ana, Ca 92706 PHONE (714) 480-7330

WORKER'S COMPENSATION - INSURANCE CARRIER \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE ( ) \_\_\_\_\_

SPECIAL INSTRUCTIONS Please review attached Medical Questionnaire for Respirator Use and send results to maus\_donald@rsccd.edu

**By authorizing treatment/medical services, I understand the company will be responsible for payment if for any reason the insurance company does not reimburse the medical provider.**

AUTHORIZED BY (Please print and sign) DON MAUS

TITLE Risk Manager PHONE (714) 480-7330 DATE \_\_\_\_\_

**FORM MUST BE COMPLETED AND SIGNED IN ORDER FOR THIS TO BE VALID**

(See map on reverse side)