

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 Respiratory Protection Evaluation Questionnaire with Medical Clearance (Initial)	OTSG APPROVED (Date) (YYYYMMDD)
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Age ____ Gender: Male ____ Female ____ Height: ____ inches Weight: ____ pounds BP ____ / ____ P ____

Type of Respirator you will wear: PAPR ____ SCBA ____ N-95 to N-100 ____ Half-face ____ Full-Face ____ M-40 ____
 Supplied Air ____ Other ____ If other, please specify: _____

Have you ever worn a respirator? Yes ____ NO ____ If yes, what type? _____

Have you had problems wearing a respirator? Yes ____ NO ____ If yes, please explain: _____

1. Do you currently smoke or have you smoked in the past month? Yes / NO

2. Have you ever had any of the following conditions?

a. Seizures Yes / NO	c. Allergic reactions that interfere with your breathing Yes / NO	e. Trouble smelling odors Yes / NO
b. Diabetes Yes / NO	d. Claustrophobia Yes / NO	f. High cholesterol Yes / NO

3. Have you ever had any of the following pulmonary or lung-problems?

a. Asbestosis Yes / NO	g. Silicosis Yes / NO
b. Asthma Yes / NO	h. Pneumothorax Yes / NO
c. Emphysema Yes / NO	i. Lung cancer Yes / NO
d. Pneumonia Yes / NO	j. Broken ribs Yes / NO
e. Tuberculosis Yes / NO	k. Any chest injury or surgery Yes / NO
f. Chronic Bronchitis Yes / NO	

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

a. Shortness of-breath Yes / NO		
b. Cough that produces phlegm Yes / NO		
c. Cough that occurs mostly when you are lying down Yes / NO		
d. Cough that wakes you early in the morning Yes / NO		
e. Coughing up blood in the last month Yes / NO		
f. Chest pain when you breathe deeply Yes / NO		
g. Shortness of breath when walking Yes / NO	If yes, does it interfere with your job?	Yes / NO
h. Wheezing Yes / NO	If yes, does it interfere with your job?	Yes / NO
i. Any other symptoms that you think may be related to lung problems Yes / NO		

5. Have you ever had any of the following cardiovascular heart symptoms?

a. Heart attack Yes / NO	d. Heart failure Yes / NO	g. Any other heart problem or condition Yes / NO
b. Stroke Yes / NO	e. Heart arrhythmia Yes / NO	
c. Angina Yes / NO	f. High blood pressure Yes / NO	

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

a. Chest tightness/pain Yes / NO	d. Heartburn or indigestion Yes / NO
b. Chest pain/tightness when working Yes / NO	e. Any other heart related symptoms Yes / NO
c. Heart skipping or missing beats Yes / NO	

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

a. Breathing or lung problems Yes / NO	c. Blood pressure Yes / NO
b. Heart trouble Yes / NO	d. Seizures Yes / NO

8. If you have wore a respirator, have you ever had any of the following problems?

a. Eye irritation Yes / NO	c. Anxiety Yes / NO
b. Skin allergies Yes / NO	d. General weakness or fatigue Yes / NO

(Continue on reverse)

PREPARED BY (Signature & Title) Occupational Health Staff	DEPARTMENT/SERVICE/CLINIC MEDDAC-PMD-OH	DATE (YYYYMMDD)
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle; grade; date; hospital or medical facility)

NAME: _____
 SSN: _____
 DOB: _____
 MOS: _____
 Job Title: _____
 Rank/Grade: _____

OTHER EXAMINATION OR EVALUATION
 Worksite Location: _____
 Duty Phone: _____

- | | |
|--|--|
| <input checked="" type="checkbox"/> HISTORY/PHYSICAL | <input type="checkbox"/> FLOW CHART |
| <input type="checkbox"/> | <input type="checkbox"/> OTHER (Specify) |
| <input type="checkbox"/> DIAGNOSTIC STUDIES | |
| <input type="checkbox"/> TREATMENT | |

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9. Have you ever Lost vision in either eye, temporarily or permanently? Yes / NO
10. Do you currently have any of the following vision concerns or problems?
 a. Wear contact lenses Yes / NO c. Color blind Yes / NO
 b. Wear glasses Yes / NO d. Any other eye or vision problem Yes / NO
11. Have you ever had and injury to -your ears, including a perforated ear drum? Yes / NO
12. Do you currently have any of the following hearing problems?
 a. Difficulty hearing or hearing loss Yes / NO
 b. Wear a hearing aid Yes / NO
 c. Any other hearing or earproblem Yes / NO If yes, please describe: _____
13. Have you ever had a back injury? Yes / NO
14. Do you currently have any of the following musculoskeletal conditions or problems?
 a. Back pain or severe stiffness Yes / NO g. Difficulty bending your knees Yes / NO
 b. Weakness in arms, hands, legs, feet Yes / NO h. Difficulty squatting Yes / NO
 c. Difficulty moving your arms or legs Yes / NO i. Difficulty bending over Yes / NO
 d. Difficulty moving head up- & down Yes / NO j. Difficulty climbing stair/ladder Yes / NO
 e. Difficulty moving head side, to side Yes / NO k. Difficulty carrying more than 20 lbs. Yes / NO
15. Would you like to talk with a physician who will review this questionnaire and your responses with you? Yes / NO

Employee Verification/Consent Statement

I verify that the above information is true and complete to the best of my knowledge. I hereby give permission for a physical examination (if needed) to determine my suitability for using a respirator. I understand that this examination is designed to satisfy regulatory requirements and should not be considered to be a routine medical examination. I agree to "self report " to my supervisor any changes in my medical condition that may affect my ability to work safely.

Full Name (print): _____ Signature: _____ Date: _____

Reviewing staff signature: _____ Date: _____

Rx

OTC

(Continue on reverse)

PREPARED BY (Signature & Title) Occupational Health Staff	DEPARTMENT/SERVICE/CLINIC MEDDAC-PMD-OH	DATE (YYYYMMDD)
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REPORT TITLE

Medical Opinion for Respiratory Fitness Evaluation

OTSG APPROVED (Date)
(YYYYMMDD)

RESULTS OF MEDICAL EVALUATION

___ Medical evaluation has detected no medical conditions that would prevent you from using a respirator.

___ Please note the following medical conditions that you should discuss with your personal primary care physician.

___ Hearing impairment that requires further evaluation. ___ See attached copy of the audiogram.

___ Impairment of visual acuity. ___ See attached copy of the vision screening tests.

___ Elevated BP. Your BP is ___ / ___.

___ Abnormal EKG. ___ See attached copy of your EKG.

___ Abnormal PFT. ___ See attached copy of your pulmonary function test.

___ Other: _____

___ Please provide us medical information regarding: _____

RESPIRATOR USE RECOMMENDATIONS

___ No restrictions on respiratory use. ___ May proceed with fit test. ___ Observe for claustrophobia during fit test.

___ Restrictions on respirator use required: _____

___ DO NOT PROCEED with FIT TEST.

___ No respirator use permitted. ___ Temporary ___ Permanent

Physician/PLHCP Stamp

Signature

Date

FIT TEST RESULTS

Fit Test Date: _____

Respirator: Brand: _____ Model: _____ Type: ___ Half-Mask ___ Full-Face Disposable: ___ Yes ___ No

___ Pass ___ Fail

Fit Test Operator Stamp

Signature

Date

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE (YYYYMMDD)

Occupational Health Staff

MEDDAC-PMD-OH

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OTHER EXAMINATION
OR EVALUATION

Worksite Location:

Duty Phone:

HISTORY/PHYSICAL

FLOW CHART

OTHER (Specify)

DIAGNOSTIC STUDIES

TREATMENT