

**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 (Periodic)

OTSG APPROVED (Date)  
(YYYYMMDD)

Complete and review prior to Annual Fit Test

NAME (Print) \_\_\_\_\_

- 1. Have you had any weight loss or gain greater than 15 pounds? \_\_\_ Yes \_\_\_ No
- 2. Have you had any facial injury or surgery that changed your features? \_\_\_ Yes \_\_\_ No
- 3. Have you developed any medical problems that limit your ability to wear a respirator? \_\_\_ Yes \_\_\_ No
- 4. Have you been treated for a heart or lung condition in the past year? \_\_\_ Yes \_\_\_ No
- 5. Have you been under treatment by a physician for any other condition in the past year? \_\_\_ Yes \_\_\_ No  
If yes, please describe: \_\_\_\_\_
- 6. Have you had any surgical or medical procedures done in the past year? \_\_\_ Yes \_\_\_ No
- 7. Have you been told by your supervisor or anyone else that you should be medically reevaluated? \_\_\_ Yes \_\_\_ No
- 8. Have there been any changes in your workplace conditions or physical requirements? \_\_\_ Yes \_\_\_ No
- 9. Have you had any chest pain or pressure while wearing a respirator? \_\_\_ Yes \_\_\_ No
- 10. Have you had to remove a respirator because of claustrophobia? \_\_\_ Yes \_\_\_ No
- 11. Have you had to remove a respirator because of shortness of breath? \_\_\_ Yes \_\_\_ No
- 12. Have you reviewed your initial respiratory questionnaire answers? \_\_\_ Yes \_\_\_ No
- 13. Are there any changes in the answers you had on the initial respiratory questionnaire? \_\_\_ Yes \_\_\_ No
- 14. What medications are you currently taking? \_\_\_\_\_ \_\_\_ Yes \_\_\_ No

It is your responsibility to report any change in health status that may affect your ability to wear a respirator to your Supervisor.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff comments on positive responses:

Reviewing staff signature: \_\_\_\_\_

Date: \_\_\_\_\_

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE (YYYYMMDD)

Occupational Health Staff

MEDDAC-PMD-OH

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:

HISTORY/PHYSICAL

FLOW CHART

OTHER (Specify)

DIAGNOSTIC STUDIES

TREATMENT

**MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA**

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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 Size: \_\_\_ S \_\_\_ M \_\_\_ L \_\_\_ R Disposable: \_\_\_ Yes \_\_\_ No

\_\_\_ Pass \_\_\_ Fail

\_\_\_\_\_  
Fit Test Operator Stamp

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

(Continue on reverse)

PREPARED BY (Signature & Title)

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