Appendix C1 – Complete/Full Medical Evaluation Questionnaire for Initial Fit Testing

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator.

1. Date _____ Employee Workday Number:_____
2. Name:_____
3. Job Department: _____Title: _____
4. Age:_____
5. Sex Male Female
6. Height: _____ Ft. _____in 6. Weight: _____ Lbs.
7. Your job title:_____ Dept.:_____
8. Phone number where you can be reached by health care professional who reviews this questionnaire:_____ The best time to phone you:_____
9. Has your employer provided you contact information for the health care professional who will review this questionnaire: Yes No
10. Check the type of respirator(s) you will use:

a. _____N,R or P Disposable respirator (filter –mask, non-cartridge type only)

b. _____Other type:(half/full face piece type, powered-air purifying ,supplied-air, SCBA):

_____

11. Have you worn a respirator? Yes No

If "yes," what type(s) _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator.

1. **Do you currently smoke tobacco, or smoked tobacco in the last month ?** Yes No
2. **Have you ever had any of the following conditions?**
   - a. Seizures Yes No
   - b. Diabetes(sugar disease) Yes No
   - c. Allergic Reactions that interfere with your breathing: Yes No
   - d. Claustrophobia (fear of closed-in places) 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

Any other lung problem 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 breath when walking at your own pace on level ground: Yes No
e. Shortness of breath when washing or dressing yourself: Yes No
Shortness of breath that interferes with your job: Yes No
Coughing that produces phlegm (thick sputum): Yes No
f. Coughing that wakes you early in the morning: Yes No
g. Coughing that occurs mostly when you are lying down: Yes No
Coughing up blood in the last month: Yes No
h. Wheezing: Yes No
i. Wheezing that interferes with your job: Yes No
j. Chest pain when you breathe deeply: Yes No
k. Any other symptoms that you think may be related to lung problems?: 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. Heart arrhythmia (heart beating irregularly): Yes No
g. High blood pressure: Yes No
h. Any other heart problem that you've 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

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 space and go to question 9.) [ ]
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 that interferes with your use of a respirator Yes No

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

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Questions 10-15 below must be answered by every employee who has been selected to use either a full face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

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 and 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 and 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 pounds Yes No
j. Any other muscle or skeletal problem that interferes with using a respirator Yes No

Employee Review and Acknowledgment

To the best of my knowledge, the information I have provided is true and accurate:

Employee Signature: _____ Date: _____

Reviewer forwarded to PLHCP for review on Date: _____

Reviewer Name (print): _____

Reviewer Signature: _____ Date: _____

Physician or other Licensed Healthcare Professional (PLHCP) Review

[ ] Employee is medically able to wear only the respirator(s) and/or face piece(s) noted about without restrictions. Employee can continue with Respirator Fit Testing Certification.

[ ] Employee must seek additional an in-person medical evaluation that may include specialty care evaluation or other level of medical care and cannot continue with Respirator Fit Testing Certification.

[ ] Other (explain, no PHI):

_____

_____

_____

[ ] Respirator use not recommended

PLCHP Name (print): _____

PLCHP Signature: _____ Date: _____

[ ] Part B of this MEQ was completed, pages 5-7, OPTIONAL.

[ ] Fit Test Certification, page 8, was issued in electronic format.

[ ] A copy of the PLHCP's written medical determination (page 4), was issued to the employee and employer.

RESPIRATOR FIT TESTING CERTIFICATION

Respirator Requested for Clearance (check all that apply):

Type of Tight-fitting Respirator:

☐ Negative Pressure (N-95)
☐ Powered Air-purifying (PAPR)
☐ Self-contained Breathing Apparatus (SCBA)
☐ Other _____

Type of Face Piece:

☐ Filtering
☐ Half Face
☐ Full Face

Fit Testing Methodology:

☐ Qualitative Fit Testing (QLFT) ☐ Quantitative Fit Testing (QNFT)
Respirator Brand Used for Testing _____
Respirator Size ☐Small ☐ Regular ☐ Other_____

Fit Testing Administrator Review and Signature:

I certify that if QNFT was utilized, the Fit Factor and Strip Chart (or other documentation) are included in this record.

☐ The employee has passed the Respiratory Fit Testing Certification for:
Respirator Brand _____ Model: _____ Size: _____
☐ Accommodations: ☐ YES ☐ NO If YES, explain:

OR

☐ The employee has not passed the Respiratory Fit Testing Certification/ the employee must:
☐ Wear a loose-fitting respirator
☐ Seek additional medical evaluation follow-up
☐ Other (explain): _____

THIS CERTIFICATION EXPIRES ON_____ (365 days from current evaluation)

Fit Testing Administrator Name (print): _____

Fit Testing Administrator Signature: _____ Date: _____

Employee Acknowledgement:

I acknowledge that I:

1. *Completed education on the storage, use and proper techniques for donning, doffing and discarding of the respirator for which I have been fitted.*
2. *Had the opportunity to ask questions or receive additional information.*
3. *Will seek additional medical evaluation if recommended above.*
4. *Received a copy of this completed form.*

Employee Name (Print): _____

Employee Signature: _____ Date: _____