GREAT LAKES
PHYSICIAN SERVICES

Last Name	First Name	Soc. Sec. Number
Address	City	State & Zip
Date of Birth	Height and Weight	Today's Date
Employer Name/Fire Company Name/Address	Race: ☐Caucasian ☐Hispanic ☐African American ☐ Asian ☐Other:_____	Home Phone

Position Held in Fire Department (check all that apply)

▫ Interior firefighter	▫ Exterior firefighter	▫ Special Team(i.e. Hazmat, SCUBA)
▫ EMS personnel	▫ Fire Police	▫ Other(list):

Respiratory Medical Evaluation Questionnaire

***** Comment on all "Yes" answers*****

Section 1

Yes	No		Comments
▫	▫	Has your employer told you how to contact the health care professional who will review this questionnaire?	
▫	▫	Will you be using an N, R, or P disposable respirator (filter-mask, non-cartridge type only)?	
▫	▫	Will you be using other types of respirators (for example: half or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).	
▫	▫	Have you worn a respirator? If "yes", what type(s)	

Section 2

Yes	No		Comments
▫	▫	Do you currently smoke tobacco, or have you smoked tobacco in the last month? Frequency?	
▫	▫	Have you ever had a Seizure?	
▫	▫	Have you ever had diabetes (sugar disease)?	
▫	▫	Do you have any allergies? (List) Specifically those allergies which interfere with your breathing?	
▫	▫	Have you ever had claustrophobia (fear of closed-in places)?	
▫	▫	Have you ever had trouble smelling odors?	

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Section 3

Yes	No		Comments
☐	☐	Have you ever been told you have asbestosis?	
☐	☐	Have you ever been told you have asthma?	
☐	☐	Have you ever been told you have chronic bronchitis?	
☐	☐	Have you ever been told you have emphysema?	
☐	☐	Have you ever been told you have pneumonia?	
☐	☐	Have you ever been told you have tuberculosis?	

Yes	No		Comments
☐	☐	Have you ever been told you have silicosis?	
☐	☐	Have you ever been told you had a pneumothorax (collapsed lung)?	
☐	☐	Have you ever been told you have lung cancer?	
☐	☐	Have you ever been told you have a broken rib(s)?	
☐	☐	Have you ever had any chest injuries or surgeries?	
☐	☐	Any other lung problems that you have been told about?	

Section 4

Yes	No		Comments
☐	☐	Do you currently have shortness of breath?	
☐	☐	Do you currently have shortness of breath when walking fast on level ground or walking up a slight hill or incline?	
☐	☐	Do you currently have shortness of breath when walking with other people at an ordinary pace on level ground?	
☐	☐	Do you currently have to stop for breath when walking at your own pace on level ground?	
☐	☐	Do you currently have shortness of breath when washing or dressing yourself?	

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☐	☐	Do you currently have shortness of breath that interferes with your job?	
☐	☐	Do you currently have a cough that produces phlegm (thick sputum)?	
☐	☐	Do you currently have a cough that wakes you early in the morning?	
☐	☐	Do you currently have a cough that occurs mostly when you are lying down?	
☐	☐	Have you coughed up blood in the last month?	
☐	☐	Do you currently have wheezing?	
☐	☐	Do you currently have wheezing that interferes with your job?	
☐	☐	Do you currently have chest pain when you breathe deeply?	
☐	☐	Do you currently have any other symptoms that you think may be related to a lung problem?	

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Section 5

Yes	No		Comments
☐	☐	Have you ever had a heart attack?	
☐	☐	Have you ever had a stroke?	
☐	☐	Have you ever had angina?	
☐	☐	Have you ever had heart failure?	
☐	☐	Have you ever had swelling in your legs or feet (not caused by walking)?	
☐	☐	Have you ever had a heart arrhythmia (heart beating irregularly)?	
☐	☐	Have you ever had high blood pressure?	
☐	☐	Have you ever been told you have any other heart problem?	

Section 6

Yes	No		Comments
☐	☐	Have you ever had frequent pain or tightness in your chest?	
☐	☐	Pain or tightness in your chest during physical activity?	
☐	☐	Pain or tightness in your chest that interferes with your job?	
☐	☐	In the past two years, have you noticed your heart skipping or missing a beat?	
☐	☐	Heartburn or indigestion that is not related to eating?	
☐	☐	Any other symptoms that you think may be related to heart or circulation problems?	

Section 7

Yes	No		Comments
☐	☐	Do you currently take medication for breathing or lung problems?	
☐	☐	Do you currently take medication for heart trouble?	
☐	☐	Do you currently take medication for blood pressure?	

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☐	☐	Do you currently take medication for seizures (fits)?	

Section 8

Yes	No		Comments
	☐	If you've never used a respirator, check the "**No**" box and go to question 9	
☐	☐	If you've used a respirator, have you **ever had** eye irritation?	
☐	☐	If you've used a respirator, have you **ever had** skin allergies or rashes?	
☐	☐	If you've used a respirator, have you **ever had** anxiety?	
☐	☐	If you've used a respirator, have you **ever had** general weakness or fatigue?	
☐	☐	If you've used a respirator, have you **ever had** any other problem that interferes with your use of a respirator	

Section 9

Yes	No		Comments
☐	☐	Would you like to talk to the health care professional who will review this questionnaire regarding your answers?	

Section 10

Yes	No		Comments
☐	☐	Have you ever lost vision in either eye (temporarily or permanently):	

Section 11

Yes	No		Comments
☐	☐	Do you currently wear contact lenses?	
☐	☐	Do you currently wear glasses? (All-purpose or reading only)	
☐	☐	Are you color blind?	
☐	☐	Do you currently have any other eye or vision problem?	

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Section 12

Yes	No		Comments
☐	☐	Have you ever had an injury to your ears, including a broken ear drum?	

Section 13

Yes	No		Comments
☐	☐	Do you currently have difficulty hearing?	
☐	☐	Do you currently wear a hearing aid?	
☐	☐	Do you currently have any other hearing or ear problem?	

Section 14

Yes	No		Comments
☐	☐	Have you ever had a back injury?	

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Part A Section 15

Yes	No		Comments
☐	☐	Do you currently have weakness in any of your arms, hands, legs, or feet?	
☐	☐	Do you currently have back pain?	
☐	☐	Do you currently have difficulty fully moving your arms and legs?	
☐	☐	Do you currently have pain or stiffness when you lean forward or backward at the waist?	
☐	☐	Do you currently have difficulty fully moving your head up or down?	
☐	☐	Do you currently have difficulty fully moving your head side to side?	
☐	☐	Do you currently have difficulty bending at your knees?	
☐	☐	Do you currently have difficulty squatting to the ground?	
☐	☐	Do you currently have difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs?	
☐	☐	Do you currently have any other muscle or skeletal problem that interferes with using a respirator?	

Medication List *

Name	*Dose*	*Frequency*

Signature: _____ Date: _____

Office Use Only

Fit Test					
Mask Type	☐ Scott	☐ MSA	☐ Other_____		
Model					
Size	☐ Small	☐ Medium	☐ Large	☐ X-Large	☐ One Size
☐ Qualitative, Irritant Smoke		☐ Quantitative, Irritant Smoke		☐ Porta-Count	

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Technician:		Result:	

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