

## MedExpress Respirator Medical Evaluation

The MedExpress Respirator Medical Evaluation questionnaire is an external document and must be completed on-line. Contact FM-OHS to receive the username and password to complete the questionnaire.

### Section A

Can you read and understand English?  Yes  No

Can you read and understand this questionnaire?  Yes  No

I attest that this form has been completed by the person named below and that I have answered all of the questions truthfully and accurately to the best of my knowledge.

Yes  No

I hereby release the form and content of my respirator "Medical Evaluation Questionnaire" (MEQ) to MEDEXPRESS and/or its representatives. This information may be reported to the physician or other licensed health care professional (PLHCP) as designated by MEDEXPRESS by e-mail, phone, fax or other method. I understand that the sole purpose of collecting and reviewing this form is to ensure that all persons are able to wear an appropriate respiratory protection device during the course of my normal employment activities or for the purposes of a drill or an actual emergency. I further understand that these evaluations are not meant, with regard to the candidate, to infer, construe or otherwise suggest any specific diagnosis nor is it an attempt to diagnose, cure or treat in any manner or by any means, methods, devices or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, defect or abnormal physical or mental condition of any person. In the event that I do not pass this evaluation, I understand that it is up to me and/or my employer to contact an appropriate physician or other licensed health care professional to resolve this matter through further evaluation. I also understand that I will not be issued a Respiratory Fit Card until such time as I receive a medical clearance from either the MEDEXPRESS PLHCP, my personal physician or my employer.

Do you agree to terms and conditions stated above?  Yes  No

Candidate Name   
First  
  
Middle  
  
Last

Date of Birth   
Month  
  
Day  
  
Year

Sex

Height  Feet

Inches  
 Weight  Pounds  
 Units    
 Job Title   
 SSN (Last 4)  Why do we need this?  
  
 Phone Number   
 Email Address

Below is the contact information for the Physician or other Licensed Health Care Professional (PLHCP) who will review your form.

**Email Address** plhcp@vestmed.com

**Work Environment**

1. What will be your work duration?

- 4-8 hours     8-12 hours

2. How often will you be working the above duration?

- Daily     2-3 times per week     Other

3. What expected additional protective clothing would you be required to wear?

- Level A:** Fully encapsulated suit, positive pressure SCBA.     **Level B:** Flash suit, chemical protective clothing, positive pressure SAR or SCBA.     **Level C:** Chemical protective clothing, air purifying respirator.     **Level D:** Standard work uniform, coveralls, safety glasses, hard hat, steel-toe boots, scrubs, gloves.

4. Your expected physical effort?

- Light Work:** Includes sitting while writing, typing, drafting, light assembly work, controlling machines.     **Moderate Work:** Includes driving, standing while drilling, nailing, performing assembly work or transferring a moderate load (about 35 lbs.) at trunk level, walking on a surface about 2 mph or down a 5-degree grade about 3 mph, or pushing a wheel barrow with a heavy load (about 100 lbs.) on a level surface.     **Heavy Work:** Includes lifting about 50 lbs., climbing stairs, walking up an 8-degree grade.

5. What would be the expected temperature and humidity extreme?

6. Select the respirators you will use (you may select more than one).

**Half-Facepiece**

- Air Purifying     Powered-Air Purifying     Supplied Air

**Full-Facepiece**

- Air Purifying     Powered-Air Purifying     Supplied Air

**Other**

- Self-Contained Breathing Apparatus     N, R, or P disposable respirator (filter-mask, non-cartridge type only, such as N95)

7. How often are you expected to use the respirator(s)? Select all that apply.

- Escape only (no rescue)     Emergency rescue only     Less than 5 hours **per week**     Less than 2 hours **per day**     2 to 4 hours per day     Over 4 hours per day

## Section B

1 Do you currently smoke tobacco, or have you smoked tobacco in the last month?  Yes  No

2 Have you ever had any of the following conditions?

A. Seizures?  Yes  No

i. Within the last five years?  Yes  No

B. Diabetes (Sugar Disease)?  Yes  No

C. Allergic reactions that interfere with your breathing?  Yes  No

D. Claustrophobia (fear of closed 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

i. Do you presently have an asthmatic condition?  Yes  No

C. Chronic Bronchitis?  Yes  No

D. Emphysema?  Yes  No

E. Pneumonia?  Yes  No

i. Have you had pneumonia within the last year?  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 chest surgeries?  Yes  No

L. Any other lung problems that you have been told about?  Yes  No

4 Have you ever had any of the following pulmonary or lung problems?

A. Shortness of breath?  Yes  No

B. Shortness of breath when walking fast on level ground or up a slight 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

F. Shortness of breath that interferes with your job?  Yes  No

G. Coughing that produces phlegm (thick sputum)?  Yes  No

H. Coughing that wakes you early in the morning?  Yes  No

I. Coughing that occurs mostly when you are lying down?  Yes  No

J. Coughing up blood in the last month?  Yes  No

K. Wheezing?  Yes  No

L. Wheezing which interferes with your job?  Yes  No

M. Chest pain when you breathe deeply?  Yes  No

N. 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 and feet (not caused by walking)?  Yes  No

F. Heart Arrhythmia?  Yes  No

G. High Blood Pressure?  Yes  No

H. Any other heart problems that you have been told about?  Yes  No

6 Have you ever had any of the following cardiovascular or heart problems?

A. Frequent pain or tightness in 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 missing or skipping 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?  Yes  No

E. Diabetes?  Yes  No

8 Have you used a respirator before?  Yes  No

A. Have you ever had eye irritation while using a respirator?  Yes  No

B. Have you ever had skin allergies or rashes while using a respirator?  Yes  No

C. Have you ever had anxiety while using a respirator?  Yes  No

D. Have you ever had general weakness or fatigue while using a respirator?  Yes  No

E. Have you ever had any other problem that interferes with your use of a respirator?  Yes  No

9 Would you like to talk to the licensed health care professional who will review this questionnaire?