PRINCE GEORGE'S COUNTY FIRE/EMS DEPARTMENT
RESPIRATORY MEDICAL EVALUATION QUESTIONNAIRE

Can you read? (circle one) Yes No

SECTION 1

1. Today's date: ___________________________________

2. Your name: _____________________________________

2a. Your Fire/EMS ID Number _______________________

3. Your age (to nearest year) ______ DOB:______

4. Sex (circle one): Male Female

5. Your height: _____ft ______in.

6. Your weight: _____lbs

7. Your job title: __________________________________

8. Phone number (include area code) _________________

9. The best time to phone you at this number:
____

10. Has your employer told you how to contact the health professional who will review this questionnaire? (circle one)
Yes No

11. Check the type of respirator you will use (you can check more than one category)
a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
b. _____ Other type (for example, half or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

12. Have you worn a respirator (circle one): Yes No
If "yes", what type (s) ___________________________

SECTION 2

The following questions may be answered by every employee/member who may have the occurrence to use a self-contained breathing apparatus (SCBA).

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

2. Have you ever had any of the following conditions?
a. Seizures (fits): 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

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 surgery: Yes No
l. Any other lung problems that you've 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 to 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 up 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 that interferes with your job Yes No
m. Chest pain when you breath 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 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. Frequent 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

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 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. Wearing a hearing aid: Yes No
c. Any other hearing problems: 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 or down: Yes No
f. Difficulty fully moving your head side to side: Yes No
g. Difficulty bending at the knees: Yes No
h. Difficulty squatting to the ground: Yes No
i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.: Yes No
j. Any other muscle or skeletal problem that interferes with using a respirator: Yes No