MedExpress Respirator Medical Evaluation

The MedExpress Respirator Medical Evaluation queationnaire is an external document and must be completed on-line. Contact FM-OHS to recive the username and password to complet 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 US Customary

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?