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 email, 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

Month  
Day
Year

Sex

Height  Feet
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 wheelbarrow 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?