Fire Academy
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Respirator Medical Evaluation Questionnaire

First Name: _____ Last Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: ○ Male ○ Female Phone: _____

Height: _____ inches Weight: _____ pounds

Have you ever worn a respirator? ○ Yes ○ No

If Yes, what type(s): _____

Type of respirator you will use:
- ○ N, R, or disposable respiratory (filter mask, non-cartridge type only).
- ○ Other Type (half- or full-face piece type, powered-air purifying, supplied air, self-contained breathing apparatus)

Do you smoke tobacco, or have you smoked tobacco in the past month?	○ Yes	○ No
Have you ever had any of the following conditions?		
Seizures (fits)?	○ Yes	○ No
Diabetes (sugar disease)?	○ Yes	○ No
Allergic reactions that interfere with your breathing?	○ Yes	○ No
Claustrophobia (fear of closed-in spaces)?	○ Yes	○ No
Trouble smelling odors?	○ Yes	○ No
Have you ever had any of the following pulmonary or lung conditions?		
Asbestosis?	○ Yes	○ No
Asthma?	○ Yes	○ No
Chronic bronchitis?	○ Yes	○ No
Emphysema?	○ Yes	○ No
Pneumonia?	○ Yes	○ No
Tuberculosis?	○ Yes	○ No
Silicosis?	○ Yes	○ No
Pneumothorax (collapsed lung)?	○ Yes	○ No

Lung cancer?	○ Yes	○ No
Broken ribs?	○ Yes	○ No
Any chest injuries or surgeries?	○ Yes	○ No
Any other lung problem you have been told about?	○ Yes	○ No

Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath?	○ Yes	○ No
Shortness of breath when walking fast on level ground or walking up a slight hill or incline?	○ Yes	○ No
Shortness of breath when walking with other people at an ordinary pace on level ground?	○ Yes	○ No
Have to stop for breath when walking at your own pace on level ground?	○ Yes	○ No
Shortness of breath when washing or dressing yourself?	○ Yes	○ No
Shortness of breath that interferes with your job?	○ Yes	○ No
Coughing that produces thick phlegm (sputum)?	○ Yes	○ No
Coughing that wakes you early in the morning?	○ Yes	○ No
Coughing that mostly occurs mostly when you are lying down?	○ Yes	○ No
Coughing up blood in the last month?	○ Yes	○ No
Wheezing?	○ Yes	○ No
Wheezing that interferes with your job?	○ Yes	○ No
Chest pain when you breathe deeply?	○ Yes	○ No
Any other symptoms you think may be related to lung problems?	○ Yes	○ No

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

Heart Attack?	○ Yes	○ No
Stroke?	○ Yes	○ No
Angina?	○ Yes	○ No
Heart failure?	○ Yes	○ No
Swelling in your legs or feet (not caused by walking)?	○ Yes	○ No
Heart arrhythmia (heart beating irregularly)?	○ Yes	○ No
High blood pressure?	○ Yes	○ No
Any other heart problem you've been told about?	○ Yes	○ No

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

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

Do you currently take medication for any of the following problems?

Breathing or lung problems?	○ Yes	○ No
Heart trouble?	○ Yes	○ No
Blood pressure?	○ Yes	○ No
Seizures (fits)?	○ Yes	○ No

If you have worn a respirator, have you experienced any of the following problems?

□ I have never worn a respirator

Eye irritation?	○ Yes	○ No
Skin allergies or rashes?	○ Yes	○ No
Anxiety?	○ Yes	○ No
General weakness or fatigue?	○ Yes	○ No
Any other problem that interferes with your use of a respirator?	○ Yes	○ No

If you will be wearing either a full-face or self contained breathing apparatus (SCBA), please answer the following:

Have you ever lost vision in either eye (temporary or permanent)?	○ Yes	○ No
Do you currently wear contact lenses?	○ Yes	○ No
Do you currently wear glasses?	○ Yes	○ No
Are you color blind?	○ Yes	○ No
Do you have any other eye or vision problem?	○ Yes	○ No

Have you ever had an injury to your ears, including a broken ear drum?

Do you currently have any of the following hearing problems?

Difficulty hearing?	○ Yes	○ No
Wear a hearing aid?	○ Yes	○ No
Any other hearing or ear problem?	○ Yes	○ No

Have you ever had a back injury?

Do you currently have any of the following musculoskeletal problems?

Weakness in any of your arms, hands, legs or feet?	○ Yes	○ No
Back pain?	○ Yes	○ No
Difficulty fully moving your arms and legs?	○ Yes	○ No

§5144. Respiratory Protection
https://www.dir.ca.gov/title8/5144.html