



OCCUPATIONAL MEDICINE & WALK-IN CLINIC

106 Heritage Parkway; Broussard, LA 70518
Phone: 337-856-7500 Fax: 337-856-7502

Respirator Medical Evaluation

This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to safely wear a respirator. We anticipate being able to approve most people for respirator use based on this questionnaire alone. In some cases we may ask for more information or additional medical testing/evaluation. Fit testing is also required and is done separately. All medical information is considered confidential.

This information must be completed for respirator approval:

Name: Age: DOB: Date:

When using respirator work is: Light Moderate Heavy

Shifts per week respirator are worn: less than 1 1-4 almost every shift

Length of time respirator are worn during shift: less than an hour 1-5 hours 5-12 hours

Medical History

Has a doctor ever told you that you have any of the following?

- YES NO Angina YES NO Diabetes treated with insulin
YES NO Heart attack YES NO Emphysema
YES NO Heart disease YES NO Asthma
YES NO Epilepsy or Seizure YES NO Are you allergic to natural rubber/latex?
Smoking History: Smoker X-Smoker Non Smoker

Explain "YES" answers:

Are you currently taking any medication? If yes, please list:

- Are you short of breath at rest? YES NO
Do you get short of breath when walking? YES NO
Do you get short of breath at work? YES NO
Do you get chest pain with certain activities? YES NO
Do you get chest pain with work? YES NO
Do you have medical problems that might interfere with respirator use? YES NO
Have you ever had problems wearing a respirator? YES NO

Explain "YES" answers:

Employee Signature: Date:

Approved Approved with restrictions Denial More information needed

Restrictions Remarks:

- David Silar, M.D.
Marissa Guidry, FNP-C
Chet Stelly, FNP-C



OCCUPATIONAL MEDICINE & WALK-IN CLINIC

106 Heritage Parkway; Broussard, LA 70518
Phone: 337-856-7500 Fax: 337-856-7502

Respirator Fit Test

Name: _____ Date: _____

Employer: _____

FIT TEST:

- Qualitative
- Other: _____

Respirator manufacturer: _____ Model: _____

Respirator size tested: _____ Respirator Style: _____

- Small Full face
- Medium Half face
- Large

While wearing the respirator, the patient had no response to the smoke irritant with:

- Normal breathing
- Deep breathing
- Head motion
- Bending over
- Talking

Remarks: _____

Test Results: PASS FAIL

Technician's signature

Date

Employee's signature