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 Heart attack
____YES ____NO Heart disease
____YES ____NO Epilepsy or Seizure
____ YES ____NO Diabetes treated with insulin
____YES ____NO Emphysema
____YES ____NO Asthma
____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 activates? >>>>>>>>>>>>>>>>>>>>>>>>>>>>>> _____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

MEDXCEL
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Respirator Fit Test

Name: _____ Date: _____

Employer: _____

FIT TEST:

- ☐ Qualitative
- ☐ Other: _____

Respirator manufacturer: _____ Model: _____

Respirator size tested:

- ☐ Small
- ☐ Medium
- ☐ Large

Respirator Style:

- ☐ Full face
- ☐ Half face

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