

**PRINCE GEORGE'S COUNTY FIRE/EMS DEPARTMENT  
RESPIRATORY MEDICAL EVALUATION QUESTIONNAIRE**

Can you read? (circle one)            Yes    No

**SECTION 1**

1. Today's date: \_\_\_\_\_
2. Your name: \_\_\_\_\_
- 2a. Your Fire/EMS ID Number \_\_\_\_\_
3. Your age (to nearest year) \_\_\_\_\_ DOB: \_\_\_\_\_
4. Sex (circle one):    Male    Female
5. Your height: \_\_\_\_\_ft \_\_\_\_\_in.
6. Your weight: \_\_\_\_\_lbs
7. Your job title: \_\_\_\_\_
8. Phone number (include area code) \_\_\_\_\_
9. The best time to phone you at this number:  
\_\_\_\_\_
10. Has your employer told you how to contact the health professional who will review this questionnaire? (circle one)  
Yes    No
11. Check the type of respirator you will use (you can check more than one category)
  - a. \_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
  - b. \_\_\_\_\_ Other type (for example, half or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)
12. Have you worn a respirator (circle one): Yes    No  
If "yes", what type (s) \_\_\_\_\_

**SECTION 2**

*The following questions may be answered by every employee/member who may have the occurrence to use a self-contained breathing apparatus (SCBA).*

1. Do you *currently* smoke tobacco, or have smoked tobacco in the last month:            Yes    No
2. Have you ever had any of the following conditions?
  - a. Seizures (fits):            Yes    No
  - b. Diabetes (sugar disease):    Yes    No
  - c. Allergic reactions that interfere with your breathing:    Yes    No
  - d. Claustrophobia (fear of closed in places):            Yes    No

3. Have you *ever* had any of the following pulmonary or lung problems?
 

a. Asbestosis:	Yes	No
b. Asthma:	Yes	No
c. Chronic bronchitis:	Yes	No
d. Emphysema:	Yes	No
e. Pneumonia:	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 surgery:	Yes	No
l. Any other lung problems that you've been told about:	Yes	No
4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
 

a. Shortness of breath:	Yes	No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or 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 to 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 up 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 that interferes with your job	Yes	No
m. Chest pain when you breath 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 or feet (not caused by walking): | Yes | No |
| f. Heart arrhythmia (heart beating irregularly):          | Yes | No |
| g. High blood pressure:                                   | Yes | No |
| h. Any other heart problem that you've been told about:   | Yes | No |

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

- |   |     |    |
|---|-----|----|
| a. Frequent pain or tightness in your chest:  | Yes | No |
| b. Frequent 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 skipping or missing 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 (fits):            | Yes | No |

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

- |   |     |    |
|---|-----|----|
| a. Eye irritation:  | Yes | No |
| b. Skin allergies or rashes:  | Yes | No |
| c. Anxiety:   | Yes | No |
| d. General weakness or fatigue:                                     | Yes | No |
| e. Any other problem that interferes with your use of a respirator: | Yes | No |

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

Yes	No
-----	----

10. Have you *ever* lost vision in either eye (temporarily or permanently):

Yes	No
-----	----

11. Do you *currently* have any of the following vision problems?

- |                                  |     |    |
|----------------------------------|-----|----|
| a. Wear contact lenses:          | Yes | No |
| b. Wear glasses:                 | Yes | No |
| c. Color blind:                  | Yes | No |
| d. Any other eye vision problem: | Yes | No |

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

Yes	No
-----	----

13. Do you *currently* have any of the following hearing problems?

- |                                |     |    |
|--------------------------------|-----|----|
| a. Difficulty hearing:         | Yes | No |
| b. Wearing a hearing aid:      | Yes | No |
| c. Any other hearing problems: | Yes | No |

14. Have you *ever* had a back injury? Yes No

15. Do you *currently* have any of the following musculoskeletal problems?

- |   |     |    |
|---|-----|----|
| a. Weakness in any of your arms, hands, legs, or feet:                            | Yes | No |
| b. Back pain:   | Yes | No |
| c. Difficulty fully moving your arms and legs:                                    | Yes | No |
| d. Pain or stiffness when you lean forward or backward at the waist:              | Yes | No |
| e. Difficulty fully moving your head up or down:                                  | Yes | No |
| f. Difficulty fully moving your head side to side:                                | Yes | No |
| g. Difficulty bending at the knees:   | Yes | No |
| h. Difficulty squatting to the ground:  | Yes | No |
| i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.: | Yes | No |
| j. Any other muscle or skeletal problem that interferes with using a respirator:  | Yes | No |