

DEPARTMENT OF HOMELAND SECURITY  
Federal Emergency Management Agency  
Center for Domestic Preparedness

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## RESPIRATORY MEDICAL EVALUATION QUESTIONNAIRE FOR STUDENTS

**Purpose:** To identify individuals having medical conditions (or past respirator experiences) who may require definitive medical evaluation by a Physician or other Licensed Health Care Professionals (PLHCP) prior to the issuance of protective masks. Only the PLHCP will review and/or have access to the information provided in this medical questionnaire.

**Patient Identification Information:**

Date:	Class Number:	Name:		
FEMA SID:		Job Title:		Phone:
Gender:	Age:	Height:	Weight:	
Reviewed by:				

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**The Privacy Act of 1974, 5 U.S.C. 552A, prohibits unauthorized release of personal data contained herein.** Routine use of the information may be used to carry out follow-up evaluations. The unauthorized Disclosure of information contained in this form could result in a violation of an individual's right to privacy. Minimum security measures require that the information contained herein be used only by authorized persons in the conduct of official business. Unauthorized disclosure of personal information, to any person not entitled to receive it, may result in a fine not more than \$5,000.00.

**Please mark "YES" or "NO" to the following questions.**

1. Have you worn a respirator/mask, Self-Contained Breathing Apparatus (SCBA), Air-Purifying Respirator (APR), or Powered Air-Purifying Respirator (PAPR)? If yes, what kind: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you currently smoke tobacco, or have you smoked tobacco in the last month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever had seizures (as an adult or/and currently under treatment)? If yes, have you been seizure-free for past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever had diabetes (sugar disease)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever had allergic reactions that interfere with your breathing? If yes, date occurred: _____ Allergic reaction to: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever had claustrophobia (fear of closed-in places)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you had a heat injury in the past 12 months that required IV fluids or hospitalization? If yes, do you have any special considerations while training in heat? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever had asbestosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever had asthma as an adult?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever had chronic bronchitis? If yes, date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please mark "YES" or "NO" to the following questions.

11. Have you ever had emphysema?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you ever had pneumonia? If yes, date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you ever had a tuberculosis diagnosis (positive TB skin test)? If yes, date of last negative (normal) chest x-ray: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you ever had silicosis (inhalation of silica/quartz dust)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Have you ever had pneumothorax (collapsed lung)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Have you ever had lung cancer, breast, colon, skin radiation, or chemotherapy? If yes, date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Have you ever had broken ribs? If yes, date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Have you ever had any chest injuries? If yes, date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Have you ever had any chest surgery(s)? If yes, what procedure: _____ Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Any other lung problem that you've been told about? If yes, describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Do you <b>currently</b> suffer from shortness of breath (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Do you <b>currently</b> suffer from shortness of breath when walking fast on level ground or walking up a slight hill or incline (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Do you <b>currently</b> suffer from shortness of breath when walking with other people at an ordinary pace on level ground (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. Do you <b>currently</b> have to stop for breath when walking at your own pace on level ground (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Do you <b>currently</b> suffer from shortness of breath when washing or dressing yourself (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26. Do you <b>currently</b> suffer from shortness of breath that interferes with your job (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
27. Do you <b>currently</b> suffer from coughing that produces phlegm (thick sputum) (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
28. Do you <b>currently</b> suffer from coughing that wakes you early in the morning (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
29. Do you <b>currently</b> suffer from coughing that occurs mostly when you are lying down (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
30. Do you <b>currently</b> suffer from coughing up blood in the past month (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
31. Do you <b>currently</b> suffer from wheezing (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
32. Do you <b>currently</b> suffer from wheezing that interferes with your job (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
33. Do you <b>currently</b> suffer from chest pain when you breathe deeply (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
34. Do you <b>currently</b> have any other symptoms that you think may be related to lung (e.g., sleep apnea) (not related to weight or sedentary lifestyle)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please mark "YES" or "NO" to the following questions.

35. Have you <b>ever had</b> a heart attack? If yes, date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
36. Have you <b>ever had</b> a stroke? If yes, date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
37. Have you <b>ever had</b> angina? (chest pain) If yes, date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
38. Have you been diagnosed with heart failure? If yes, date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
39. Have you <b>ever had</b> swelling in your legs or feet (not caused by walking)? If yes, date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
40. Have you <b>ever had</b> heart arrhythmia (irregular heartbeat, fast, slow, skipping)? If yes, describe any limitations or restrictions related to heart arrhythmia:	<input type="checkbox"/> Yes <input type="checkbox"/> No
41. Have you <b>ever had</b> high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
42. Have you <b>ever had</b> any other heart problem that you've been told about? If yes, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
43. Do you <b>currently</b> have any cardiovascular or heart-related limitations or restrictions? If yes, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
44. Are you currently under the care of a medical doctor for any condition related to pulmonary problems, lung illness, heart, or cardiovascular problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
45. Have you <b>ever had</b> frequent pain or tightness in your chest?	<input type="checkbox"/> Yes <input type="checkbox"/> No
46. Have you <b>ever had</b> pain or tightness in your chest during physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
47. Have you <b>ever had</b> pain or tightness in your chest that interferes with your job?	<input type="checkbox"/> Yes <input type="checkbox"/> No
48. Have you <b>ever had</b> heartburn or indigestion not related to eating? If yes, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
49. In the past two years, have you noticed your heart skipping or missing a beat? Any other symptoms? If yes, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
50. Have you ever had eye irritation caused by using a respirator?	<input type="checkbox"/> Yes <input type="checkbox"/> No
51. Have you ever had skin allergies or rashes caused by using a respirator?	<input type="checkbox"/> Yes <input type="checkbox"/> No
52. Have you ever experienced anxiety while using a respirator?	<input type="checkbox"/> Yes <input type="checkbox"/> No
53. Have you ever experienced general weakness or fatigue while using a respirator? Any other problems that interfere with your use of a respirator:	<input type="checkbox"/> Yes <input type="checkbox"/> No
54. Have you ever been hospitalized or had surgery in the past year? If yes, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Please mark "YES" or "NO" to the following questions.

<p>55. Have you <b>ever lost</b> vision in either eye temporarily or permanently? If yes, date: _____ Describe:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>56. Do you currently wear contact lenses?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>57. Do you currently wear glasses?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>58. Are you color blind?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>59. Do you have any other eye or vision problems? If yes, describe:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>60. Have you <b>ever had</b> an injury to your ears, including a punctured or ruptured eardrum? If yes, date: _____ Describe:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>61. Do you currently have difficulty hearing?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>62. Do you currently wear a hearing aid?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>63. Do you currently have any other hearing or ear problems? If yes, describe:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>64. Have you ever had a back injury? If yes, date: _____ Describe any limitations or restrictions:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>65. Do you <b>currently</b> have weakness in any of your arms, hands, legs or feet?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>66. Do you <b>currently</b> have back pain?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>67. Do you <b>currently</b> have difficulty fully moving your arms and legs?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>68. Do you <b>currently</b> have pain or stiffness when you lean forward or backward at the waist?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>69. Do you <b>currently</b> have difficulty moving your head up and down?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>70. Do you <b>currently</b> have difficulty moving your head side to side?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>71. Do you <b>currently</b> have difficulty bending at your knees?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>72. Do you <b>currently</b> have difficulty squatting to the ground?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>73. Do you <b>currently</b> have difficulty climbing a flight of stairs or ladder carrying more than 25 pounds? If yes, describe:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>74. Do you <b>currently</b> have any other muscle or skeletal problem that interferes with using a respirator?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>75. Do you <b>normally</b> wear any form of back brace or other form of brace or prosthesis? If yes, describe:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>76. Will any of the muscle or skeletal problems listed above limit or prevent you from completing required training?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Please mark "YES" or "NO" to the following questions.

77. Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
78. Have you delivered a baby or experienced a miscarriage in the past 90 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
79. Do you have a medical condition that affects your immune system (i.e., lupus, rheumatoid arthritis, cancer)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
80. Have you ever served in the military?	<input type="checkbox"/> Yes <input type="checkbox"/> No
81. Would you like to speak to the Physician or Licensed Health Care Professional (PLHCP) who will review this questionnaire?	<input type="checkbox"/> Yes <input type="checkbox"/> No
82. Do you currently take any medications for breathing or lung issues (e.g., inhalers, steroids, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
83. Do you currently take any medications for heart symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
84. Do you currently take any medications for blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
85. Do you currently take any medications for seizures (fits)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
86. Do you currently take any medications for any other medical problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
87. Have you in the past taken corticosteroids for longer than 3 months at a time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
88. Have you taken corticosteroids daily in the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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89. List all medications		
Name of Medication	Frequency	Condition