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

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, many 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: _____	☐ Yes ☐ No
2.	Do you currently smoke tobacco, or have you smoked tobacco in the last month?	☐ Yes ☐ 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?	☐ Yes ☐ No ☐ Yes ☐ No
4.	Have you ever had diabetes (sugar disease)?	☐ Yes ☐ No
5.	Have you ever had allergic reactions that interfere with your breathing? If yes, date occurred: _____ Allergic reaction to: _____	☐ Yes ☐ No
6.	Have you ever had claustrophobia (fear of closed-in places)?	☐ Yes ☐ 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? _____	☐ Yes ☐ No
8.	Have you ever had asbestosis?	☐ Yes ☐ No
9.	Have you ever had asthma as an adult?	☐ Yes ☐ No
10.	Have you ever had chronic bronchitis? If yes, date: _____	☐ Yes ☐ No

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

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

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

35.	Have you ***ever had*** a heart attack? If yes, date: _____	☐ Yes ☐ No
36.	Have you ***ever had*** a stroke? If yes, date: _____	☐ Yes ☐ No
37.	Have you ***ever had*** angina? (chest pain) If yes, date: _____	☐ Yes ☐ No
38.	Have you been diagnosed with heart failure? If yes, date: _____	☐ Yes ☐ No
39.	Have you ***ever had*** swelling in your legs or feet (not caused by walking)? If yes, date: _____	☐ Yes ☐ No
40.	Have you ***ever had*** heart arrhythmia (irregular heartbeat, fast, slow, skipping)? If yes, describe any limitations or restrictions related to heart arrhythmia:	☐ Yes ☐ No
41.	Have you ***ever had*** high blood pressure?	☐ Yes ☐ No
42.	Have you ***ever had*** any other heart problem that you've been told about? If yes, describe:	☐ Yes ☐ No
43.	Do you ***currently*** have any cardiovascular or heart-related limitations or restrictions? If yes, describe:	☐ Yes ☐ 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?	☐ Yes ☐ No
45.	Have you ***ever had*** frequent pain or tightness in your chest?	☐ Yes ☐ No
46.	Have you ***ever had*** pain or tightness in your chest during physical activity?	☐ Yes ☐ No
47.	Have you ***ever had*** pain or tightness in your chest that interferes with your job?	☐ Yes ☐ No
48.	Have you ***ever had*** heartburn or indigestion not related to eating? If yes, describe:	☐ Yes ☐ No
49.	In the past two years, have you noticed your heart skipping or missing a beat? Any other symptoms? If yes, describe:	☐ Yes ☐ No ☐ Yes ☐ No
50.	Have you ever had eye irritation caused by using a respirator?	☐ Yes ☐ No
51.	Have you ever had skin allergies or rashes caused by using a respirator?	☐ Yes ☐ No
52.	Have you ever experienced anxiety while using a respirator?	☐ Yes ☐ 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:	☐ Yes ☐ No
54.	Have you ever been hospitalized or had surgery in the past year? If yes, describe:	☐ Yes ☐ No

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

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

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

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

89. List all medications

Name of Medication	Frequency	Condition