



Office of the Assistant Secretary for Preparedness and Response
National Disaster Medical System
National Postal Model

Respirator Medical Evaluation Questionnaire

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

Can you read? (select one):

Yes No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print). Today's date :

Name

USPS Employee ID

Age

Height (ft, in)

Weight (lbs)

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):

The best time to phone you at this number:

USPS Office:

Has your employer told you how to contact the health care professional who will review this questionnaire (select one):

Yes No

Have you worn a respirator (select one):

Yes No

If "yes", what type(s):

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please select "yes" or "no").

Please explain all yes answers at the end of the form.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes No

2. Have you ever had any of the following conditions?

- Seizures (fits) Yes No
Diabetes (sugar disease) Yes No
Allergic reactions that interfere with your breathing Yes No
Claustrophobia (fear of closed-in-places) Yes No
Trouble smelling odors Yes No

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

- Asbestosis Yes No
Asthma Yes No
Chronic bronchitis Yes No
Emphysema Yes No
Pneumonia Yes No
Tuberculosis Yes No
Silicosis Yes No
Pneumothorax (collapsed lung) Yes No
Lung cancer Yes No
Broken ribs Yes No
Any chest injuries or surgeries Yes No
Any other lung problem that you've been told about Yes No

**4. Do you currently have any of the following symptoms of pulmonary or lung illness?**

- Shortness of breath  Yes  No
- Shortness of breath when walking fast on level ground or walking up a slight hill or incline  Yes  No
- Shortness of breath when walking with other people at an ordinary pace on level ground  Yes  No
- Have to stop for breath when walking at your own pace on level ground  Yes  No
- Shortness of breath when washing or dressing yourself  Yes  No
- Shortness of breath that interferes with your job  Yes  No
- Coughing that produces phlegm (thick sputum)  Yes  No
- Coughing that wakes you early in the morning  Yes  No
- Coughing that occurs mostly when you are lying down  Yes  No
- Coughing up blood in the last month  Yes  No
- Wheezing  Yes  No
- Wheezing that interferes with your job  Yes  No
- Chest pain when you breathe deeply  Yes  No
- Any other symptoms that you think may be related to lung  Yes  No

**5. Have you ever had any of the following cardiovascular or heart problems?**

- Heart attack  Yes  No
- Stroke  Yes  No
- Angina  Yes  No
- Heart failure  Yes  No
- Swelling in your legs or feet (not caused by walking)  Yes  No
- Heart arrhythmia (heart beating irregularly)  Yes  No
- High blood pressure  Yes  No
- 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?**

- Frequent pain or tightness in your chest  Yes  No
- Pain or tightness in your chest during physical activity  Yes  No
- Pain or tightness in your chest that interferes with your job  Yes  No
- In the past two years, have you noticed your heart skipping or missing a beat  Yes  No
- Heartburn or symptoms that is not related to eating  Yes  No
- 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?**

- Breathing or lung problems  Yes  No
- Heart trouble  Yes  No
- Blood pressure  Yes  No
- 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)**

- Eye irritation  Yes  No
- Skin allergies or rashes  Yes  No
- Anxiety  Yes  No
- General weakness or fatigue  Yes  No
- 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

**Please explain all yes answers in detail including diagnosis if any, treatment if any, ongoing symptoms, pertinent dates if/how affects daily activity and any medication you are currently taking. Please attach additional pages if more space is needed.**