Pulmonary Function Study

Name:	SS#:	DOB:
Address:	City:	State, Zip:
Phone (home):	(work):	Sex: F M
Employer:	Dept:	Job:
Race:	Height: (inches)	Weight (pounds)

Medical History	**Clear Checks**	**Yes**	**No**	**Comment**
1. Any previous problems wearing a respirator?				
2. Have you had a heart attack or heart disease?				
3. Do you have asthma or other lung disease?				
4. Have you had seizures, a stroke or blackouts?				
5. Have you had any back injuries or other musculoskeletal problems?				
6. Do you have claustrophobia (fear of tight spaces)?				
7. Have you had shortness of breath or dizziness when performing regular daily activities at home or at work?				
8. Do you have persistent cough or wheezing?				
9. Do you have unexplained weakness or fatigue?				
10. Do you have any medical conditions that would interfere with your ability to work wearing a respirator?				
11. Are you currently taking any medications that would interfere with your ability to work wearing a respirator?				
12. Any surgeries?				
13. Smoking history:				

If yes, number cigarettes/day or pack/day: _____

Total number of years: _____

If former smoker, years/months since quitting: _____

Number cigarettes/day or packs/day for years: _____

Pulmonary Function Testing

Forced Vital Cpacity (FVC)_____

Forced Expiratory Volume (FEVI)_____

Forced Expiratory Flow (FEF 25-75)_____

Temperature (Celsius)_____

Barometric Pressure (mmHg)_____

Comments:

Examination By:_____ Date: _____