Respirator Medical Evaluation Questionnaire

Student ID: _____Healthcare College: _____

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

1. Today's date: _____

2. Your name: _____

3. Date of Birth _____ Your age (to nearest year): _____

4. Your height: _____ft. _____in.

5. Your weight: _____lbs.

6. Your job title: _____

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

8. The best time to phone you at this number (circle one): Morning -or- Afternoon -or- Early Evening

9. Has your college told you how to contact the health care professional who will review this questionnaire (**circle one**): **Yes** -or- **No**

10. Check the type of respirator you will use (you can check more than one category):

    a. ___ N-95

    b. ___ Powered-air purifying (PAPR)

11. Have you previously worn a respirator (circle one): Yes -or- No

If "yes," what type(s): _____

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

- You may be asked to schedule a follow up medical examination with Student Health to review a positive yes response to any question among questions 1-8.

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

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

a. Seizures 2*a. Yes / No

b. Diabetes (sugar disease) 2*b. Yes / No

c. Allergic reactions that interfere with your breathing 2*c. Yes / No

d. Claustrophobia (fear of closed-in places) 2*d. Yes / No

e. Trouble smelling odors 2*e. Yes / No

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

a. Asbestosis	3*a. Yes / No
b. Asthma	3*b. Yes / No
c. Chronic bronchitis	3*c. Yes / No
d. Emphysema	3*d. Yes / No
e. Pneumonia	3*e. Yes / No
f. Tuberculosis	3*f. Yes / No
g. Silicosis	3*g. Yes / No
h. Pneumothorax (collapsed lung)	3*h. Yes / No
i. Lung cancer	3*i. Yes / No
j. Broken ribs	3*j. Yes / No
k. Any chest injuries or surgeries	3*k. Yes / No
l. Any other lung problem that you've been told about	3*l. Yes / No

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

a. Shortness of breath	4*a. Yes / No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	4*b. Yes / No
c. Shortness of breath when walking with other people at an ordinary pace on level ground	4*c. Yes / No
d. Have to stop for breath when walking at your own pace on level ground	4*d. Yes / No
e. Shortness of breath when washing or dressing yourself	4*e. Yes / No
f. Shortness of breath that interferes with your job	4*f. Yes / No
g. Coughing that produces phlegm (thick sputum)	4*g. Yes / No
h. Coughing that wakes you early in the morning	4*h. Yes / No
i. Coughing that occurs mostly when you are lying down	4*i. Yes / No
j. Coughing up blood in the last month	4*j. Yes / No

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k. Wheezing	4*k. Yes / No
l. Wheezing that interferes with your job	4*l. Yes / No
m. Chest pain when you breathe deeply	4*m. Yes / No
n. Any other symptoms that you think may be related to lung problems	4*n. Yes / No

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

a. Heart attack	5*a. Yes / No
b. Stroke	5*b. Yes / No
c. Angina	5*c. Yes / No
d. Heart failure	5*d. Yes / No
e. Swelling in your legs or feet (not caused by walking)	5*e. Yes / No
f. Heart arrhythmia (heart beating irregularly)	5*f. Yes / No
g. High blood pressure	5*g. Yes / No
h. Any other heart problem that you've been told about	5*h. Yes / No

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

a. Frequent pain or tightness in your chest	6*a. Yes / No
b. Pain or tightness in your chest during physical activity	6*b. Yes / No
c. Pain or tightness in your chest that interferes with your job	6*c. Yes / No
d. In the past two years, have you noticed your heart skipping or missing a beat	6*d. Yes / No
e. Heartburn or indigestion that is not related to eating	6*e. Yes / No
f. Any other symptoms that you think may be related to heart or circulation problems	6*f. Yes / No

7*. Do you currently take medication for any of the following problems?

a. Breathing or lung problems	7*a. Yes / No
b. Heart trouble	7*b. Yes / No
c. Blood pressure	7*c. Yes / No
d. Seizures	7*d. Yes / No

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8*. If you've previously worn a respirator, did you ever experience any of the following issues while using the respirator? (If you've NEVER used a respirator (i.e. N95), check the following box and go to question 9.) = ☐

a. Eye irritation 8*a. Yes / No

b. Skin allergies or rashes 8*b. Yes / No

c. Anxiety 8*c. Yes / No

d. General weakness or fatigue 8*d. Yes / No

e. Any other problem that interferes with your use of a respirator 8*e. Yes / No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? 9. Yes / No

Student Signature: _____ Date: _____

Student Health RN Signature: _____ Date: _____