Loyola Medical Center Respirator Medical Evaluation Questionnaire

Can you read?     Yes             No

1. Today’s Date ______________________
2. Name:_______________________________________
3. Age to nearest year______________
4. Sex  Male      Female
5. Height:______Ft._____________in
6. Weight:_______________Lbs.
7. Your job title:_____________   Dept.:_____________________
8. Phone number where you can be reached:_______ _______ ____________
9. Has your employer told you how to contact Employee Health:  yes  No
   a. ____X____ N,R or P Disposable respirator (filter–mask, non-cartridge type only)
10. Have you worn a respirator?  Yes  No
    If “yes,” what type(s)

Part A. Section 2.) Questions below must be answered by every employee who has been selected to use any type of respirator (please circle “yes” or “no”).

1. Do you currently smoke tobacco ?:  Yes  No
2. Have you ever had any of the following conditions?
   a. Seizures:                               Yes  No
   b. Diabetes(sugar disease):               Yes  No
   c. Allergic Reactions that interfere with your breathing: Yes  No
   d. Claustrophobia (fear of closed-in places): Yes  No
   e. Trouble smelling odors:                Yes  No
3. Have you ever had any of the following pulmonary or lung problems?
   a. Asbestosis:                             Yes  No
   b. Asthma:                                 Yes  No
   c. Chronic bronchitis:                     Yes  No
   d. Emphysema:                              Yes  No
   e. Pneumonia:                              Yes  No
   f. Tuberculosis:                           Yes  No
   g. Silicosis:                              Yes  No
   h. Pneumothorax (collapsed lung):          Yes  No
   i. Lung cancer:                            Yes  No
   j. Broken Ribs:                            Yes  No
   k. Any chest injuries or surgeries:        Yes  No
   l. Any other lung problem that you have been told about: Yes  No
4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath:                    Yes  No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:  
   Yes  No

c. Shortness of breath when walking with other people at an ordinary pace on level ground:  
   Yes  No
d. Have to stop for breath when walking at your own pace on level ground:  
   Yes  No
e. Shortness of breath when washing or dressing yourself:  
   Yes  No
f. Shortness of breath that interferes with your job:  
   Yes  No
g. Coughing that produces phlegm (thick sputum):  
   Yes  No
h. Coughing that wakes you early in the morning:  
   Yes  No
i. Coughing that occurs mostly when you are lying down:  
   Yes  No
j. Coughing up blood in the last month:  
   Yes  No
k. Wheezing:  
   Yes  No
l. Wheezing that interferes with your job:  
   Yes  No
m. Chest pain when you breathe deeply:  
   Yes  No
n. Any other symptoms that you think may be related to lung problems:  
   Yes  No

5. Have you ever had any of the following cardiovascular or heart problems?  
   a. Heart attack:  
      Yes  No  
   b. Stroke:  
      Yes  No  
   c. Angina:  
      Yes  No  
   d. Heart failure:  
      Yes  No  
   e. Swelling in your legs or feet (not caused by walking):  
      Yes  No  
   f. Heart arrhythmia (heart beating irregularly):  
      Yes  No  
   g. High blood pressure:  
      Yes  No  
   h. 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?  
   a. Frequent pain or tightness in your chest:  
      Yes  No  
   b. Pain or tightness in your chest during physical activity:  
      Yes  No  
   c. Pain or tightness in your chest that interferes with your job:  
      Yes  No  
   d. In the past two years, have you noticed your heart skipping or missing a beat:  
      Yes  No  
   e. Heartburn or indigestion that is not related to eating:  
      Yes  No  
   f. 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?  
   A. Breathing or lung problems:  
      Yes  No  
   B. Heart trouble:  
      Yes  No  
   C. Blood Pressure:  
      Yes  No  
   D. 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): [ ]  
   a. Eye irritation:  
      Yes  No  
   b. Skin allergies or rashes:  
      Yes  No  
   c. Anxiety:  
      Yes  No
d. General weakness or fatigue: Yes No
e. 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

10. Have you ever lost vision in either eye (temporarily or permanently): Yes No

11. Do you currently have any of the following vision problems:
   a. Wear contact lenses: Yes No
   b. Wear glasses: Yes No
c. Color blind: Yes No
d. Any other eye or vision problem: Yes No

12. Have you ever had an injury to your ears, including a broken ear drum: Yes No

13. Do you currently have any of the following hearing problems:
   a. Difficulty hearing: Yes No
   b. Wear a hearing Aid: Yes No
c. Any other hearing or ear problem: Yes No

14. Have you ever had a back injury: Yes No

15. Do you currently have any of the following musculoskeletal problems:
   a. Weakness in any of your arms, hands, legs or feet Yes No
   b. Back pain: Yes No
c. Difficulty fully moving your arms and legs: Yes No
d. Pain or stiffness when you lean forward or backward at the waist: Yes No
e. Difficulty fully moving your head up and down: Yes No
f. Difficulty fully moving your head side to side: Yes No
g. Difficulty bending at your knees: Yes No
h. Difficulty squatting to the ground: Yes No
i. Climbing a flight of stairs or a ladder carrying more than 25 pounds: Yes No
j. Any other muscle or skeletal problem that interferes with using a respirator: Yes No

All yes responses in Part a Section 2 must be reviewed by licensed medical professional in Loyola EHS
[] Yes responses reviewed and should not interfere with wearing mask.
[] Yes responses reviewed and further data required
[] Yes responses reviewed and patient unable to wear respirator

Medical Clearance: To be completed by Loyola EHS
[] Fit for respirator use with no restrictions
[] Fit for respirator use mild restrictions or accommodations (see Limitations)
[] Additional testing needed before fitness can be determined
[] Not fit for respirator use

Limitations: ___________________________ ___________________________

Signature Medical Provider: __________________________ Date: __________________________