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: