

Loyola Medical Center Respirator Medical Evaluation Questionnaire

Can you read? Yes No

1. Today's Date _____
2. Name: _____
3. Age to nearest year: _____ Date of Birth : _____
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/Student Health: Yes No
10. Have you worn a respirator ? Yes No

Type : Disposable respirator (filter –mask, non-cartridge type only)
 other _____

Part A. Section 2.) questions below must be answered by every employee/student 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

*****below line office use only

All yes responses in Part A Section 2 must be reviewed by licensed medical professional at Loyola

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 Employee/Student Health or Designate

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: _____