Wheaton Franciscan Healthcare

Respirator Medical Evaluation Questionnaire

Can you read? ☐ Yes ☐ No

Would you like assistance in completing this questionnaire? ☐ ***Yes*** ☐ ***No***

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

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

1. Today's date:	2. Your name:
3. Your age (to nearest year):	4. Sex (select one): ☐ Male ☐ Female
5. Your height: __ Feet __ inches	6. Your weight: ___ lbs.
7. Do you have a full facial beard? ☐ Yes ☐ No	
8. Your department and job title:	
9. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code):	
10. The best time to phone you at this number:	
11. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No	
12. Check the type of respirator you will use. (You may check more than one category.) a. ☐ N (Non-Oil), ☐ R (Oil Resistant), or ☐ P (Oil Proof) disposable respirator (i.e., filter-mask/N95, non-cartridge type only.) b. ☐ Other type (i.e., half or full-face piece type, powered-air purifying, supplied-air, self contained breathing apparatus.) ☐ Powered Air Purifying Respirator (PAPR) ☐ Half Face Piece ☐ Other: _____	
13. Have you worn a respirator? ☐ Yes ☐ No If "yes", what type(s): _____	

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

	Yes	No
1. Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month? If yes:	☐	☐
At what age did you start smoking? _____		
How long ago did you quit smoking? _____		
How many packs per day did or do you smoke? _____		
2. Have you ***ever had*** any of the following conditions?		
a. Seizures (fits) Type _____	☐	☐
Date of last seizure _____		
b. Diabetes (sugar disease)	☐	☐
Have you ever lost consciousness or had a change in level of consciousness?	☐	☐
If yes, when? _____		
c. Allergic reactions that interfere with your breathing?	☐	☐
If yes, when? _____		
If yes, describe _____		
d. Claustrophobia (fear of closed-in places)	☐	☐
e. Trouble smelling odor	☐	☐
3. Have you ***ever had*** any of the following pulmonary or lung problems?		
a. Asbestosis	☐	☐
b. Asthma	☐	☐
c. Chronic bronchitis	☐	☐
d. Emphysema	☐	☐
e. Pneumonia	☐	☐
f. Tuberculosis	☐	☐
g. Silicosis	☐	☐
h. Pneumothorax	☐	☐
i. Lung cancer	☐	☐
j. Broken rib	☐	☐
k. Any chest injuries or surgeries	☐	☐
l. Any other lung problem that you've been told about?	☐	☐
If yes to any of the above, please describe, including when: _____		
_____		
_____		
4. Do you ***currently have*** any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	☐	☐
b. Shortness of breath when walking fast on level ground or up a slight hill or incline	☐	☐
c. Shortness of breath when walking with others at an ordinary pace on ground level	☐	☐
d. Have to stop for breath when walking at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐

	Yes	No
f. Shortness of breath that interferes with your job	☐	☐
g. Coughing that produces phlegm (thick sputum)	☐	☐
h. Coughing that wakes you early in the morning	☐	☐
i. Coughing that occurs mostly when you are lying down	☐	☐
j. Coughing up blood in the last month	☐	☐
k. Wheezing	☐	☐
l. Wheezing that interferes with your job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. Any other symptoms that you think may be related to lung problems	☐	☐

If yes to any of the above, please describe _____

_____

_____

_____

_____

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

a. Heart attack	☐	☐
b. Stroke	☐	☐
c. Angina	☐	☐
d. Heart failure	☐	☐
e. Swelling in your legs or feet (not caused by walking)	☐	☐
f. Heart arrhythmia (heart beating irregularly)	☐	☐
g. High blood pressure	☐	☐
If yes, is it under control?	☐	☐
h. Any other heart problem that you've been told about	☐	☐

If yes to any of the above, please describe, including when: _____

_____

_____

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

a. Frequent pain or tightness in your chest	☐	☐
b. Pain or tightness in your chest during physical activity	☐	☐
c. Pain or tightness in your chest that interferes with your job	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
e. Heartburn or indigestion that is not related to eating	☐	☐
f. Any other symptoms that you think may be related to heart or circulation problems	☐	☐

If yes to any of the above, please describe, including when: _____

_____

_____

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

a. Breathing or lung problems	☐	☐

	Yes	No
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures (fits)	☐	☐
8. If you've used a respirator, have you ***ever had*** any of the following problems during respirator use? *[If you have never used a respirator, check the following box and go to question 9 ☐]*	☐	☐
a. Eye irritation	☐	☐
b. Skin allergies or rashes	☐	☐
c. Anxiety	☐	☐
d. General weakness or fatigue	☐	☐
e. Any other problem that interferes with your use of a respirator	☐	☐
If yes, please describe _____		
9. Are you ***currently*** taking any medications? If yes, please list here:	☐	☐
_____		
_____		
_____		
_____		
_____		
10. Would you like to talk to the health care professional that reviews this questionnaire about your answers to this questionnaire?	☐	☐
For any "Yes" answers in section 2 (questions 1-9 above), does this condition interfere with your ability to wear a respirator?	☐	☐

Comments: _____

_____

_____

_____

_____

_____ _____

ASSOCIATE SIGNATURE **DATE**

Associate Health & Wellness Department Use Only

- ☐ Approved
- ☐ Approved with restrictions

_____

- ☐ Pulmonary function test and follow-up medical evaluation indicated
- ☐ Denied
- ☐ More Information needed

Remarks: _____

_____

_____

_____ _____

SIGNATURE **DATE**