OHSU | Tuality Healthcare

N95 and PAPR respiratory medical evaluation questionnaire

Return to:
Employee Health Services, OHSU Tuality Healthcare | 335 SE 8th Hillsboro, OR 97123 | FAX: (503) 681-4170

Full name: _____ Department: _____

PART A: SECTION 1: (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (*please print*).

Age: _____ Sex: ❒ M ❒ F Height: _____ Weight: _____ Job Title: _____

Tel: _____ Best time to phone you at this number: _____ ❒ am ❒ pm

Check the type of respirator you will use (you can check more than one category):
❒ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
❒ Other type (ex. Half or full-face type, powered-air purifying, supplied air, self contained breathing apparatus)

Have you worn a respirator: ❒ Yes ❒ No

If yes, what type(s): _____

PART A: SECTION 2: (Mandatory) Questions 1-9 must be answered by every employee who has been selected to use any type of respirator (*please check yes or no*):

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ❒ Yes ❒ No

2. Have you ever had any of the following conditions?
   a. Seizures (fits): ❒ 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 flowing pulmonary or lung problems?

a. Asbestosis	❒ Yes ❒ No		g. Silicosis	❒ Yes	❒ No
b. Asthma	❒ Yes ❒ No		h. Pneumothorax (collapsed lung)	❒ Yes	❒ No
c. Chronic bronchitis	❒ Yes ❒ No		i. Lung cancer	❒ Yes	❒ No
d. Emphysema	❒ Yes ❒ No		j. Broken ribs	❒ Yes	❒ No
e. Pneumonia	❒ Yes ❒ No		k. chest injuries or surgeries	❒ Yes	❒ No
f. Tuberculosis	❒ Yes ❒ No				

Other lung problem that you've been told about: _____

Full name: _____ Department: _____

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 breath deeply? ❒ Yes ❒ No
   n. Any other symptoms that you thing 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 problems 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 2 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? ❒ 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 ❒ Yes ❒ No

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8. If you've used a respirator, have you **ever** had any of the following problems (if you've never used a respirator continue 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 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 permanent)? ❒ 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 or 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

Please use area provided below, to explain any "yes" responses in detail:

_____

_____

_____

Full name: _____ Department: _____

_____

_____

_____

I understand the above questions and certify that all statements and answers are accurate and true to the best of my knowledge.

I consent to undergo any additional examination, including x-rays, and/or spirometry (lung function) test, which may be necessary to complete this evaluation.

_____ _____

Signature Date