NorthShore
University HealthSystem

RESPIRATOR MEDICAL EVALUATION FORM
PART I

NOTE: ALL PERSONNEL REQUIRED TO USE RESPIRATORS MUST COMPLETE THIS QUESTIONAIRE

Name (Print): _____ Date: _____

Address: _____

Signature:_____Dept. if NorthShore employee:_____

To the employer:
"Yes" answers to questions in Section 1, and to question 9 in Section 2 do not require a medical examination.

To the employee: 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.

Can you read English? (Check one): ❑ Yes ❑ No

Section 1
Every employee who has been selected to use any type of respirator (please print) must provide the following information.

1. Date of birth: _____
2. Sex (check one): ❑ Male ❑ Female
3. Your height: _____ ft. _____ in.
4. Your weight: _____ lbs.
5. Your job title: _____
6. A phone number where you can be reached by the health care professional who reviews this questionnaire: (___)_____
7. The best time to phone you at this number: _____
8. Has your employer told you how to contact the health care professional who will review this questionnaire (check one): ❑ Yes ❑ No
9. Check the type of respirator you will use (you can check more than one category):
   X___ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   ____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)
10. Have you worn a respirator? (Check one): ❑ Yes ❑ No
11. If "yes," list type(s)_____

Section 2
Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no").):

YES	NO	
❑	❑	**1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?**
		2. Have you ever had any of the following conditions:
❑	❑	Seizures (fits)?
❑	❑	Allergic reactions that interfere with your breathing?
❑	❑	Claustrophobia (fear of closed-in places)?
❑	❑	Trouble smelling odors?
❑	❑	Diabetes?

3. Have you ever had any of the following pulmonary or lung problems:

YES	NO	
❑	❑	Asbestosis?
❑	❑	Asthma?
❑	❑	Chronic bronchitis?
❑	❑	Emphysema?
❑	❑	Pneumonia?
❑	❑	Tuberculosis?
❑	❑	Silicosis?
❑	❑	Pneumothorax (collapsed lung)?
❑	❑	Lung cancer?
❑	❑	Broken ribs?
❑	❑	Any chest injuries or surgeries?
❑	❑	Any other lung problem that you've been told about?

4. Do you currently have any of the following symptoms of pulmonary or lung illness:

❑	❑	Shortness of breath?
❑	❑	Shortness of breath when walking fast on level ground, or walking up a slight hill or incline?
❑	❑	Have to stop for breath when walking at your own pace on level ground?
❑	❑	Shortness of breath when washing or dressing yourself?
❑	❑	Shortness of breath that interferes with your job?
❑	❑	Coughing that produces phlegm (thick sputum)?
❑	❑	Coughing that wakes you early in the morning?
❑	❑	Coughing that occurs mostly when you are lying down?
❑	❑	Coughing up blood in the last month?
❑	❑	Wheezing?
❑	❑	Wheezing that interferes with your job?
❑	❑	Chest pain when you breathe deeply?
❑	❑	Any other symptoms that you think may be related to lung problems?

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

❑	❑	Heart attack?
❑	❑	Stroke?
❑	❑	Angina?
❑	❑	Heart failure?
❑	❑	Swelling in your legs or feet (not caused by walking?
❑	❑	Heart arrhythmia (heart beating irregularly)?
❑	❑	High blood pressure?
❑	❑	Any other heart problem that you've been told about?

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

❑	❑	Frequent pain or tightness in your chest?
❑	❑	Pain or tightness in your chest that interferes with your job?
❑	❑	In the past two years, have you noticed your heart skipping or missing a beat?
❑	❑	Heartburn or indigestion that is not related to eating?
❑	❑	Any other symptoms that you think may be related to heart or circulation problems?

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

❑	❑	Breathing or lung problems?
❑	❑	Heart trouble?
❑	❑	Seizures (fits)?

8. If you've used a respirator, have you ever had any of the following problems:

❑	❑	Eye irritation?
❑	❑	Skin allergies or rashes?
❑	❑	Anxiety?
❑	❑	General weakness or fatigue?
❑	❑	Any other problem that interferes with your use of a respirator?

❑ ❑ **9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Phone number:**_____