



Health Services

N-95 and Powered Air-Purifying Respirator Medical Evaluation Questionnaire

Printed Name:			Sex: (circle) Male Female	
DOB:	Dept:	Credentials (MD, DO, APRN, etc.):		
Your age (to the nearest year):	Height:	ft.	in.	Weight: lbs.
Name of Hospital/Organization Credentialed at:				

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____ Best time to reach you at this number: _____

Would you like to speak with the health care professional who reviews this questionnaire (circle one): Yes / No

Please answer the following questions and explain all YES answers in the space provided below

1. Do you currently smoke tobacco or have you smoked tobacco within the past month? Packs/day _____ Number of years _____			Yes	No	
2. Have you ever had any of the following conditions?					
Seizures	Yes	No	Diabetes	Yes	No
Claustrophobia	Yes	No	Trouble smelling odors	Yes	No
Allergic reactions that interfere with your ability to breathe			Yes	No	
3. Have you ever had any of the following pulmonary or lung problems?					
Asbestosis	Yes	No	Asthma	Yes	No
Chronic Bronchitis	Yes	No	Emphysema	Yes	No
Pneumonia	Yes	No	Tuberculosis	Yes	No
Silicosis	Yes	No	Pneumothorax	Yes	No
Lung cancer	Yes	No	Broken ribs	Yes	No
Any chest injuries or surgeries	Yes	No	Any other lung problem	Yes	No
4. Do you currently have any of the following symptoms of pulmonary or lung illness?					
Shortness of breath			Yes	No	
Shortness of breath when walking fast on level ground or walking up a slight hill/incline			Yes	No	
Shortness of breath when walking with other people at an ordinary pace on level ground			Yes	No	
Have to stop for breath when walking at your own pace on level ground			Yes	No	
Shortness of breath when dressing yourself			Yes	No	
Shortness of breath that interferes with your job			Yes	No	
Coughing that produces phlegm			Yes	No	
Coughing that wakes you early in the morning			Yes	No	
Coughing that occurs mostly when you are lying down			Yes	No	
Coughing up blood in the last month			Yes	No	
Wheezing			Yes	No	
Wheezing that interferes with your job			Yes	No	
Chest pain when you breathe deeply			Yes	No	
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?					
Heart attack	Yes	No	Stroke	Yes	No
Angina	Yes	No	Heart failure	Yes	No
Swelling in legs/feet	Yes	No	Heart arrhythmia	Yes	No
High blood pressure	Yes	No	Any other heart problem	Yes	No
6. Have you ever had any of the following cardiovascular or heart symptoms?					
Frequent pain or tightness in your chest			Yes	No	
Pain or tightness in your chest during physical activity			Yes	No	
Pain or tightness in your chest that interferes with your job			Yes	No	
In the past two years, have you noticed your heart skipping or missing a beat			Yes	No	
Heartburn or indigestion that is not related to eating			Yes	No	
Any other symptoms that you think may be related to heart or circulation problems			Yes	No	

7. Do you <u>currently</u> take medication for any of the following problems?					
Breathing or lung problems	Yes	No	Heart trouble	Yes	No
Blood pressure	Yes	No	Seizures	Yes	No
8. If you've used an N-95 respirator or Powered Air-Purifying Respirator (PAPR) in the past, have you <u>ever had</u> any of the following problems? If you've never used a N95 respirator or PAPR, check the following and go to question 9. <input type="checkbox"/>					
Eye Irritation	Yes	No	Skin allergies or rash	Yes	No
Anxiety	Yes	No	General weakness or fatigue	Yes	No
Any other problem that interferes with your use of a respirator?				Yes	No
9. Do you grow a beard or mustache at any point during the year?				Yes	No

Please thoroughly explain all YES answers: _____

I affirm that I have answered all of the above questions to the best of my knowledge and that the answers are accurate and complete.

 Provider Signature

 Date

This section is to be completed by Health Nurse/Licensed Healthcare Provider only:

Comments regarding Yes answers: _____

Medically cleared for respirator use: 5 year review - 2 year review
 Medically cleared for respirator use with the following restrictions _____
 Medical evaluation is indicated, not medically cleared for respirator use

Reviewed by: _____ Date: _____
(Licensed Healthcare Provider Signature/Title)

This section for Occupational Health Provider notes only:

Notes: _____

Medically cleared for respirator use
 Medically cleared for respirator use with the following restrictions _____
 Medical evaluation is indicated, not medically cleared for respirator use

Reviewed by: _____ Date: _____
(Occupational Medical Provider Signature/Title)