HSHS Sacred Heart St.Joseph's St.Vincent St.Mary's St.Nicholas St.Clare | PREVEA health

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

Printed Name:			**Sex:** ☐ 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 ☐ 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 **currently** 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 **ever had** any of the following problems? If you've never used a N95 respirator or PAPR, check the following and go to question 9. ☐					
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: _____

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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: _____

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☐ 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: _____

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☐ 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)