

Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____ Resp _____			
	WNL	ABN	Comments
General Appearance			
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Neurological			
Skin			
CHRONIC MEDICAL CONDITIONS REVIEWED <input type="checkbox"/> Stable <input type="checkbox"/> Recommend follow-up			

Provider Name _____

Date _____

Signature _____

NPI # _____

Organization _____

OSHA Respirator Medical Evaluation STUDENT Questionnaire

Name: _____ **Today's Date:** _____ **Hospital / Facility Assigned:** _____

DOB: _____ Age (to nearest year) _____

School: _____ Program: _____

Gender: Male Female Not disclosed

Height: _____ feet _____ inches Weight: _____ pounds

Contact information where you can be reached by the health care professional reviewing this questionnaire:

Check the type of respirator you have worn in the past (check more than one category if applicable or leave blank if unknown):

- N-95: Make: _____ Model: _____ Size: _____
- PAPR: Hood Size: _____
- Other: _____

- Phone (include area code) _____
- Email: _____

1. Do you currently or have you smoked tobacco during the previous month?

Yes No

If yes:

- a. At what age did you start smoking? _____
- b. How long ago did you quit smoking? _____
- c. How many packs per day did or do you smoke? _____

Yes No

2. Have you ever had any of the following conditions?

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Seizures (fits) |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Diabetes (sugar disease) |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Allergic reactions that interfere with your breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Claustrophobia (fear of closed-in places) |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Trouble smelling odors |

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

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Asbestosis |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Chronic bronchitis |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Silicosis |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Pneumothorax (collapsed lung) |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Lung cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Broken ribs |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Any chest injuries or surgeries |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Any other lung problem that you have been told about |

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

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Heart attack |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Angina |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Heart failure |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Swelling in your legs or feet (not caused by walking) |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Heart arrhythmia (heart beating irregularly) |
| <input type="checkbox"/> | <input type="checkbox"/> | g. High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Any other heart problem that you have been told about |

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

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Frequent pain or tightness in your chest |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Pain or tightness in your chest during physical activity |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Pain or tightness in your chest that interferes with your job |
| <input type="checkbox"/> | <input type="checkbox"/> | d. In the previous 2 years, have you noticed your heart skipping or missing a beat? |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Heartburn or indigestion that is not related to eating |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Any other symptoms that you think might be related to heart or circulation problems |

Yes No

6. Do you currently have any of the following symptoms of pulmonary or lung illness?

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Shortness of breath when walking quickly on level ground or walking up a slight hill or incline |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Shortness of breath when walking with other people at an ordinary pace on level ground |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Have to stop for breath when walking at your own pace on level ground |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Shortness of breath when washing or dressing yourself |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Shortness of breath that interferes with your job |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Coughing that produces phlegm (thick sputum) |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Coughing that wakes you early in the morning |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Coughing that occurs primarily when you are lying down |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Coughing up blood in the last month |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Wheezing |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Wheezing that interferes with your job |
| <input type="checkbox"/> | <input type="checkbox"/> | m. Chest pain when you breathe deeply |
| <input type="checkbox"/> | <input type="checkbox"/> | n. Any other symptoms that you think might be related to lung problems |

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

- | | | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Breathing or lung problems |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Heart trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Seizures (fits) |

8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator check here and go to question 9.)

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Eye irritation |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Skin allergies or rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | d. General weakness and fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Any other problems that interferes with your use of a respirator |

9. Are you currently taking any medications? If yes, list.

10. Has your employer told you how to contact the health care professional who will review this questionnaire: Yes No

11. Would you like to talk with the health-care professional who will review this questionnaire about your answers to this questionnaire? Yes No

Please explain any "yes" answers (use back of form if necessary)

Student Signature: _____

Date: _____

Healthcare Professional

Opinion on Student Fitness for PAPR Use:

Signature: _____ Date: _____