William R. Sharpe, Jr. Hospital
Respirator Medical Evaluation Questionnaire

Instructions: Please complete all sections of this questionnaire and return it to Infection Control only.

Part A.

1. Today's date:_____
2. Your Name:_____
3. Birthdate:_____
4. Sex (circle one): male female
5. Your height:_____ft._____in.
6. Your weight:_____lbs.
7. Your Department and job title:_____R.N. L.P.N. C.N.A._____
8. A phone number where you can be reached by the medical reviewer:_____
9. The best time to phone you at this number:_____
10. Have you worn a respirator (circle one): yes no
    If yes, what type(s):_____

Part B.

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: 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 following pulmonary or lung problems?
   a. Asbestosis: yes no
   b. Asthma: yes no
   c. Emphysema: yes no
   d. Chronic bronchitis: yes no
   e. Pneumonia: yes no
   f. Tuberculosis: yes no
   g. Silicosis: yes no
   h. Pneumothorax (collapsed lung): yes no
   i. Lung cancer: yes no
   j. Broken ribs: yes no
   k. Any chest injuries or surgeries: yes no
   l. Any other lung problem that you've been told about: yes no

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 breathe 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 lets 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 problem 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 problems: 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

8. If you've used a respirator, have you **ever had** any of the following problems?
   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 your use of a respirator: yes no

9. Would you like to talk to the medical evaluator who will review this questionnaire about your answers to this questionnaire: yes no

William R. Sharpe, Jr. Hospital
Request For Medical Clearance For Respirator Use

Employee Name: **Date of Birth:**
Name of Immediate Supervisor: Dwight Sawyers **Worker Job Title:** R.N. L.P.N. C.N.A.
Type of Respirator: Powered Air Purifying Respirator **Purpose:** Protect worker from tuberculosis
Level & Duration of Work Effort: Variable from light 200 kcal/hr, moderate 300 kcal/hr, heavy more than 300 kcal/hr or strenuous involving emergency responses such as aggression management, resusitation, heavy cleaning, patient lifting, & maintenance repairs to the room
Frequency of Use: Rarely
Job Description & Work Conditions:

Medical Evaluator Report:

☐No Restrictions on Respirator Use

☐Some Specific Use Restrictions

☐No Respirator Permitted

Restrictions:_____

_____

_____

_____ _____
Medical Evaluator Date of Evaluation