INDIANA UNIVERISTY RESPIRATOR MEDICAL QUESTIONNAIRE

This questionnaire will be used in determining whether or not you have a medical condition that may affect your ability to wear a respirator. All medical information is considered confidential.

Part A. Section 1				
Name:			Today's Date:	
DOB: / /	Sex: M / F	Age:	Height:	Weight:
Are you: IU Employee____ MD____ IUSOM Faculty____ Resident/Fellow_____ Student_____			IU User Name:	
Department:	Manager:		Job Title:	
How best to reach you:	Best time to call:		Phone/Pager:	

1.Check the type of Respirator you will use and state the manufacturer name:
Half-face APR ___,Type ____________ Full-face APR ___, Type _____________ PAPR ___, Type ____________

SAR ___, Type ____________ SCBA ___, Type ____________

Disposable Respirator (N-95, used for TB/SARs, Q-fever, particles), Type __________________________________

2. Have you worn a respirator before? Now___ Past___
If "Yes", what type(s) ____

Part A. Section 2		
Please check the appropriate box below	**NO**	**YES**
1. Do you **currently** smoke tobacco, or have you smoked in the last month?		Now___ Past___
2. Have you **ever had** any of the following conditions? a. Seizures (fits):		Now___ Past___
b. Diabetes (sugar disease):		Now___ Past___
c. Allergic reactions that interfere with you breathing:		Now___ Past___
d. Claustrophobia (fear of closed-in places):		Now___ Past___
e. Trouble smelling odors:		Now___ Past___
3. Have you ever had any of the following pulmonary or lung problems? a. Asbestosis		Now___ Past___
b. Asthma		Now___ Past___
c. Chronic bronchitis		Now___ Past___
d. Emphysema		Now___ Past___
e. Pneumonia:		
f. Tuberculosis:		Now___ Past___
g. Silicosis		Now___ Past___
h. Pneumothorax (collapsed lung)		Now___ Past___
i. Lung cancer:		Now___ Past___
j. Broken ribs		Now___ Past___
k. Other chest injuries/surgeries		Now___ Past___
l. Any other lung problem that you've been told about:		Now___ Past___
4. Do you **currently have** any of the following symptoms of pulmonary or lung illness? a. Shortness of breath		
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:		
c. Shortness of breath when walking with other people at an ordinary pace on level ground:		
d. Have to stop for breath when walking at your own pace on level ground:		
e. Shortness of breath when washing or dressing yourself:		
f. Shortness of breath that interferes with your job:		
g. Coughing that produces phlegm (thick sputum):		
h. Coughing that wakes you early in the morning:		
i. Coughing that occurs mostly when you are lying down:		
j. Coughing up blood in the last month:		
k. Wheezing:		
l. Wheezing that interferes with your job:		

m. Chest pain when you breathe deeply:		
n. 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***? a. Heart Attack:		Now___ Past___
b. Stroke:		Now___ Past___
c. Angina:		Now___ Past___
d. Heart failure:		Now___ Past___
e. Swelling in your legs or feet (not caused by walking):		Now___ Past___
f. Heart arrhythmia (heart beating irregularly):		Now___ Past___
g. High blood pressure:		Now___ Past___
h. Any other heart problem that you've been told about:		Now___ Past___
6. Have you **ever had** any of the following cardiovascular or heart ***symptoms***? a. Frequent pain or tightness in your chest:		Now___ Past___
b. Pain or tightness in your chest during physical activity:		Now___ Past___
c. Pain or tightness in your chest that interferes with your job:		Now___ Past___
d. In the past two years, have you noticed your heart skipping or missing a beat:		Now___ Past___
e. Heartburn or indigestion that is not related to eating:		Now___ Past___
f. Any other symptoms that you think may be related to heart or circulation problems:		Now___ Past___
7. Do you currently take medication for any of the following problems? a. Breathing or lung problems:		
b. Heart trouble		
c. Blood pressure:		
d. Seizures (fits):		
8. If you've ever used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check here ________):		
a. Eye irritation:		
b. Skin allergies or rashes:		
c. Anxiety that occurs only when you use the respirator:		
d. General weakness or fatigue:		
e. 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?		

The following questions must be answered by employees who will use either a full-facepiece respirator or an SCBA.

Please check appropriate box below	**NO**	**YES**
1. Have you **ever lost** vision in either eye (temporarily or permanently):		Now___ Past ___
2. Do you currently have any of the following vision problems? a. Wear contact lenses:		
b. Wear glasses:		
c. Color blind:		
d. Any other eye or vision problem:		
3. Have you **ever had** an injury to your ears, including a broken ear drum:		Now___ Past ___
4. Do you **currently** have any of the following hearing problems? a. Difficulty hearing:		
b. Wear a hearing aid:		
c. Any other hearing or ear problem:		
5. Have you **ever had** a back injury?		Now___ Past ___
6. Do you **currently** have any of the following musculoskeletal problems? a. Weakness in any of your arms, hands, legs, or feet:		
b. Back pain:		
c. Difficulty fully moving your arms or legs:		
d. Pain or stiffness when you lean forward or backward at the waist:		

Please check appropriate box below	**NO**	**YES**
e. Difficulty fully moving your head up or down:		
f. Difficulty fully moving your head side to side:		
g. Difficulty bending at your knees:		
h. Difficulty squatting to the ground:		
i. Climbing a flight of stairs or a ladder carrying more than 25 pounds:		
j. Any other muscle or skeletal problem that interferes with using a respirator:		

If you answered “Yes” to any of the above questions, please provide more information (e.g. specific diagnoses, medications, symptoms) in the space below:

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You make talk to the health care professional reviewing this questionnaire. Please contact IUEHS for your respective campus for contact information.

Employees Signature: ____ **Date:**_____________________