GEORGETOWN UNIVERSITY HOSPITAL
RESPIRATORY PROTECTION PROGRAM

MEDICAL EVALUATION QUESTIONNAIRE

I. Do you need assistance reading the Questionnaire? (circle one): YES/NO

II. Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at your answers, and you must forward via company mail or hand deliver your questionnaire, after completion, to Employee Health. Employee Health may assist you, as needed, with completing this questionnaire.

Part A. Section 1.0

The following information must be provided by every employee who has been selected to use any type of respirator (**please print**).

1. Today's date:______________________________________
2. Your name:____
3. Your age (to the nearest year):________________________
4. Sex (circle one): Male/Female
5. Your height:____________ft. _______________inches
6. Your weight:____________lbs.
7. Your job title:______________________________________
8. A phone number where you can be reached by Employee Health who will review this questionnaire (include are code)___________________________
9. The best time to contact you at the number you listed:________________
10. Has your supervisor or management informed you how to contact Employee Health who will review this questionnaire (circle one): Yes/No
11. Check the type of respirator you will use (you can check more then one category):

    a._____ N, R or P type disposable respirator (filter mask, non-cartridge type only, i.e., **N95**). *R & P Type are not used by GUH.*

b._____ Other type (half or full-face type respirator, air purifying (cartridge type), supplied air (i.e., PAPR), or self contained breathing apparatus).

12. Have you ever worn a respirator (circle one): Yes/No If yes, what type(s):____

Part A. Section 2.0

Questions 1 through 9 must be answered by every employee who has been selected to use any type of respirator (circle "yes" or "no").

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: 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

   f. Latex allergy diagnosed by a physician: Yes/No

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

   a. Asbestosis: Yes/No

   b. Asthma: Yes/No

   c. Chronic bronchitis: Yes/No

   d. Emphysema: 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 problems 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 walking 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 when you are mostly 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 breath deeply: Yes/No

   n. Any other symptoms that you think would 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 legs 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 problems that you have been told about: Yes/No

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

    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 two years have you noticed your heart skipping or missing a beat: Yes/No

    e. Heart burn 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? (If you've never used a respirator, check the following space ☐ and go to question 9).

    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 Employee Health, who will review this questionnaire, about your answers to this questionnaire: Yes/No

Questions 10 - 15, below, must be answered by every employee who has been selected to use **full-face piece respirator.**

10. Have you ever lost vision in either eye (temporarily or permanently): Yes/No

11. Do you currently have any of the following vision problems?

    Wear contact lenses: Yes/No

    Wear glasses: Yes/No

    Color blind: Yes/No

    Any other eye or vision problem: Yes/No

12. Have you ever had any injury to your ears, including a broken ear drum: Yes/No

13. Do you currently have any of the following hearing problems?

    a. Difficulty hearing: Yes/No

    b. Wear a hearing aid: Yes/No

    c. Any other hearing or ear problem: Yes/No

14. Have you ever had a back injury: Yes/No

15. Do you currently have any of the following musculoskeletal problems?

    a. Weakness in any of your arms, hands, legs or feet: Yes/No

    b. Back pain: Yes/No

    c. Difficulty moving your arms and legs: Yes/No

    d. Pain or stiffness when you move forwards or backwards at your waist: Yes/No

    e. Difficulty moving your head up or down, or side to side: Yes/No

    f. Difficulty bending at your knees: Yes/No

    g. Difficulty squatting to the ground: Yes/No

    h. Climbing a flight of stairs or ladder carrying more than 25 lbs: Yes/No

i. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Part B.

1. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g. gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

2. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No If "yes" describe the protective clothing and/or equipment: ___________________________________

3. Will you be working under hot conditions (temperature exceeding 77° F): Yes/No

4. Will you be working under humid conditions: Yes/No

5. Will you be using any of the following items with your respirator(s)?

   HEPA Filter(s): Yes/No

   Cartridges: Yes/No

6. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?

   Over 4 hours per day: Yes/No

   2 to 4 hours per day: Yes/No

   Less than 2 hours per day: Yes/No

   Less than 5 hours per week: Yes/No

7. Describe the work you will be doing while you're using your respirator(s):____

   ____

Reviewed EHS by ____

Clinician Date