

**UNIVERSITY EMPLOYEE HEALTH CLINIC
(UEHC)
RESPIRATOR FITNESS QUESTIONNAIRE
(Hospital)**

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DATE
ID #
NAME
BIRTHDATE

The University of Iowa Employee Health Clinic (UEHC) requests this information for the purpose of assuring patient care. This is confidential medical information and the UEHC does not routinely provide this information without your written consent.

IF NOT IMPRINTED, PLEASE PRINT DATE, ID #, NAME

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 or review your answers and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it. Please forward when completed to our Campus Address: UEHC, BT 1097-1.

Can you read? (circle one) YES / NO

Mandatory The following information must be provided by every employee who has been selected to use any type of respirator.

(Please print)

Today's date: _____ Employee job title: _____

Employee name: _____ Day time phone #: _____

Employee age: _____ Sex: Male/Female Height: _____ft. _____in. Weight: _____lbs.

Check the type of respirator you will use (you may check more than one category):

- ____ N, R, or P disposable respirator (filter mask, non-cartridge type only)
____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

Have you worn a respirator? No/Yes If yes, what type? _____

Questions 1 to 9 - Mandatory

CIRCLE APPROPRIATE ANSWERS (No/Yes and circle corresponding letters)

1. Do you **currently** smoke tobacco or have you smoked tobacco in the last month? No/Yes
2. Have you **ever had** any of the following conditions? No/Yes
 - a. Seizures (fits)
 - b. Diabetes (sugar disease)
 - c. Allergic reactions that interfere with your breathing
 - d. Claustrophobia (fear of closed-in places)
 - e. Trouble smelling odors
3. Do you **currently** take medication for any of the following problems? No/Yes
 - a. Breathing or lung problems
 - b. Heart trouble
 - c. Blood pressure
 - d. Seizures (fits)
4. Have you **ever had** any of the following pulmonary or lung problems? No/Yes
 - a. Asbestosis
 - b. Asthma
 - c. Chronic bronchitis
 - d. Emphysema
 - e. Pneumonia
 - f. Tuberculosis
 - g. Silicosis
 - h. Pneumothorax (collapsed lung)
 - i. Lung cancer
 - j. Broken ribs
 - k. Any chest injuries or surgeries
 - l. Any other lung problem that you've been told about

NAME:

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RESPIRATOR FITNESS QUESTIONNAIRE (cont'd)

5. Do you **currently** have any of the following symptoms of pulmonary or lung illness? No/Yes
- 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
6. Have you **ever had** any of the following cardiovascular or heart problems? No/Yes
- a. Heart attack
 - b. Stroke
 - c. Angina
 - d. Heart failure
 - e. Swelling in your legs or feet (not caused by walking)
 - f. Heart arrhythmia (heart beating irregularly)
 - g. Any other heart problem that you've been told about
 - h. Have you ever had any treatment for any of the above in the past 10 years?
7. Have you **ever had** any of the following cardiovascular or heart symptoms? No/Yes
- a. Frequent pain or tightness in your chest
 - b. Pain or tightness in your chest during physical activity
 - c. Pain or tightness in your chest that interferes with your job
 - d. In the past two years, have you noticed your heart skipping or missing a beat
 - e. Heartburn or indigestion that is not related to eating
 - f. Any other symptoms that you think may be related to heart or circulation problems
8. If you've used a respirator, have you **ever had** any of the following problems? No/Yes
(If you've never used a respirator, check the following space and go to question 9): _____
- a. Eye irritation
 - b. Skin allergies or rashes
 - c. Anxiety
 - d. General weakness or fatigue
 - e. Any other problem that interferes with your use of a respirator
9. Would you like to talk about the answers to this questionnaire with the health care professional reviewing it? Yes/No

_____ / _____ Date

Patient Signature PLHCP Signature

_____ Date

NP/PA/MD Signature

OFFICE USE ONLY (Patient does not complete)

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RESPIRATOR FITNESS MEDICAL FORM

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The Respirator Medical Evaluation Questionnaire has been reviewed. The PLHCP (Physician or other Licensed Health Care Professional) opinion is listed below:

1. Limitations on respirator use related to the medical condition of the employee or the workplace conditions in which the respirator will be used:

None

Must use PAPR (Powered Air-Purifying Respirator)

If the respirator currently used by the employee is a negative pressure respirator and the PLHCP finds a medical condition that may place the employee's health at increased risk if the respirator is used, the employer shall provide a PAPR if the PLHCP's medical evaluation finds that the employee can use such a respirator.

The following restrictions apply: _____

2. The employee:

IS medically able to use the respirator

is NOT medically able to use the respirator

3. A follow-up medical evaluation is needed:

Yes

No

Employee Signature: _____

PLHCP Signature: _____ Date: _____