An Occupational Health professional is responsible for reviewing this medical questionnaire and for determining if you are medically capable and safe to wear a respirator. Contact Occupational Health for questions regarding this form and medical evaluation.

**Section 1 (Mandatory)**: Every employee who has been selected to wear any type of respirator must provide all the below information. **Please type or print.**

|  |  |
| --- | --- |
| LEGAL LAST NAME FIRST NAME MI    | TODAY’S DATEClick or tap to enter a date. |
| SEX [ ]  Female[ ]  Male | HEIGHT WEIGHT  | BIRTHDATE and/or EMPLOYEE ID # SSN LAST 4-DIGITS  | AGE (to nearest year)  |
| BEST CONTACT NUMBER BEST TIME TO CALL YOU AT THIS NUMBER [ ]  AM [ ]  PM |
| EMPLOYER: The University of Kansas Health System [ ]  candidate [ ]  employee [ ]  The University of Kansas Physicians (UKP) [ ]  The University of Kansas Medical Center (KUMC) [ ]  KUMC GME (Resident/Fellow) |
| POSITION/TITLE | DEPARTMENT |
| MANAGER’S NAME |

**Section 2. (Mandatory) Every employee who has been selected to use any type of respirator will answer questions 1 through 9 below (please check “Yes” or “No”)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **QUESTION** | **Yes** | **No** | **QUESTION** | **Yes** | **No** |
| **1.** Have you worn a respirator? |[ ] [ ]   |  |  |
| If yes, what type(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **2.** Have you ***ever had*** any of the following conditions? | **4.** Do you ***currently*** have any of the following symptoms of pulmonary or lung illness? |
| 1. Seizures (fits)
 |[ ] [ ]  1. Shortness of breath
 |[ ] [ ]
| 1. Diabetes (sugar disease)
 |[ ] [ ]  1. Shortness of breath when walking fast on ground or
 |[ ] [ ]
| 1. Allergic reactions that interfere with breathing
 |[ ] [ ]  walking up a slight hill or incline |  |  |
| 1. Claustrophobia (fear of closed-in places)
 |[ ] [ ]  1. Shortness of breath when walking with other people
 |[ ] [ ]
| 1. Trouble smelling odors
 |[ ] [ ]  at an ordinary pace on level ground |  |  |
| **3.** Have you ***ever had*** any of the following pulmonary or lung problems? | 1. Have to stop for breath when walking at your own
 |[ ] [ ]
| 1. Asbestosis
 |[ ] [ ]  pace on level ground |  |  |
| 1. Asthma
 |[ ] [ ]  1. Shortness of breath when washing or dressing
 |[ ] [ ]
| 1. Chronic bronchitis
 |[ ] [ ]  yourself |  |  |
| 1. Emphysema
 |[ ] [ ]  1. Shortness of breath that interferes with your job
 |[ ] [ ]
| 1. Pneumonia
 |[ ] [ ]  1. Coughing that produces phlegm (thick sputum)
 |[ ] [ ]
| 1. Tuberculosis
 |[ ] [ ]  1. Coughing that wakes you early in the morning
 |[ ] [ ]
| 1. Silicosis
 |[ ] [ ]  1. Coughing that occurs mostly when you are lying down
 |[ ] [ ]
| 1. Pneumothorax (collapsed lung)
 |[ ] [ ]  1. Coughing up blood in the last month
 |[ ] [ ]
| 1. Lung Cancer
 |[ ] [ ]  1. Wheezing
 |[ ] [ ]
| 1. Broken ribs
 |[ ] [ ]  1. Wheezing that interferes with your job
 |[ ] [ ]
| 1. Any chest injuries or surgeries
 |[ ] [ ]  1. Chest pain when you breathe deeply
 |[ ] [ ]
| 1. Any other lung problem that you’ve been told about
 |[ ] [ ]  1. Any other symptoms that you think may be related to a

lung problem |[ ] [ ]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| QUESTION | **Yes** | **No** | **QUESTION** | **Yes** | **No** |
| **5.** Have you ***ever had*** any of the following cardiovascular  |  |  | **7.** Do you *currently* take medication for any of the following problems? |
| or heart problems? |  |  | 1. Breathing or lung problems
 |[ ] [ ]
| 1. Heart attack
 |[ ] [ ]  1. Heart trouble
 |[ ] [ ]
| 1. Stroke
 |[ ] [ ]  1. Blood pressure
 |[ ] [ ]
| 1. Angina
 |[ ] [ ]  1. Seizure (fits)
 |[ ] [ ]
| 1. Heart failure
 |[ ] [ ]  **8.** If you’ve never used a respirator, check here [ ]  and go to #9. |
| 1. Swelling in your legs or feet (not caused
 |[ ] [ ]  If you’ve used a respirator, have you *ever had* any of the following |
| by walking) |  |  | problems? |
| 1. Heart arrhythmia (heart beating irregularly)
 |[ ] [ ]  1. Eye irritation
 |[ ] [ ]
| 1. High blood pressure
 |[ ] [ ]  1. Skin allergies or rashes
 |[ ] [ ]
| 1. Any other heart problem that you’ve been told about
 |[ ] [ ]  1. Anxiety
 |[ ] [ ]
| **6.** Have you ***ever had*** any of the following cardiovascular  | 1. General weakness or fatigue
 |[ ] [ ]
| or heart symptoms? |  |  | 1. Any other problems that interferes with your use of a
 |[ ] [ ]
| 1. Frequent pain or tightness in your chest
 |[ ] [ ]  respirator |  |  |
| 1. Pain or tightness in your chest during physical activity
 |[ ] [ ]   |  |  |
| 1. Pain or tightness in your chest that interferes with your
 |[ ] [ ]   |  |  |
| job |  |  |  |
| 1. In the past 2 years, have you noticed your heart
 |[ ] [ ]   |
| skipping or missing a beat |  |  |  |
| 1. Heartburn or indigestion that is not related to eating
 |[ ] [ ]   |  |  |
| 1. Any other symptoms that you think may be related to
 |[ ] [ ]  **9.** Would you like to talk to an Occupational Health, |[ ] [ ]
| heart circulation problems |  |  | healthcare professional about your answers? |  |  |

|  |
| --- |
| Please briefly comment on the “Yes” or positive responses from any section: |
|  |
|  |
|  |
| **To the best of my ability, I affirm that the information completed on this form is true and correct.****I will submit to Occupational Health located t Delp G110 or occ@kumc.edu, for a provider review and medical evaluation completion.** |
|  **Electronic Signature**  | **Date**  |
|  ***Print Name:***  |  |

# OFFICIAL USE ONLY: RESPIRATOR MEDICAL EVALUATION (by Licensed health care professional)

*Responses above determine the provider’s medical opinion and the employee’s ability to be N95 respirator fit tested and/or wear a PAPR.*

**N95 Fit Testing** [ ]  Cleared [ ]  Failed **Powered Air Purifying Respirator (PAPR)** [ ]  Cleared to don [ ]  Failed to don

**Medical opinion for failure is due to:**









 Click or tap to enter a date.

***Reviewing Provider Signature******DATE***