

TB/N95 RESPIRATOR PROGRAM 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.

Please Print. Please answer all questions (1-10). Date: _____

Name: ID/SSN: Email

Date of Birth: / / Sex: M / F Age: Height: Weight:

Department: Cost Center: Job Title:

How best to reach you: Best time to call: Phone/Pager:

1. Check the type of Respirator you will use: _____ N95 Disposable Respirator (used for TB/SARS pt care)
 _____ Other (if other, what kind: _____)

Please check appropriate boxes below **NO YES**

2. Have you worn a respirator before? If "yes", what type(s): _____		
3. Do you currently smoke tobacco, or have you smoked in the last month?		
4. Have you ever had any of the following conditions?		
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:		
5. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis:		
b. Asthma/Silicosis		
c. Chronic bronchitis:		
d. Emphysema:		
e. Pneumonia:		
f. Tuberculosis:		
g. Pneumothorax (collapsed lung):		
h. Lung cancer:		
i. Broken ribs:		
j. Any chest injuries or surgeries:		
k. Any other lung problem that you've been told about: _____		
6. 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		

<i>Please check appropriate box below</i>	NO	YES
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		
7. Have you ever had any of the following cardiovascular or heart problems?		
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. High blood pressure		
h. Any other heart problem that you've been told about:		
8. Have you ever had any of the following cardiovascular or heart symptoms?		
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		
9. 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)		
10. If you have never used a respirator, check here _____. You are now finished. If you have ever used a respirator, did you have any of the following:		
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		

**You may talk to the health care professional who will review this questionnaire by calling:
I.U. P.U.I Health Services @ (317) 274-8214**