PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

Name: _____

Medical Record / PeopleSoft ID: _____ / _____

Medical Evaluation Request and Questionnaire for Users of N95 Disposable Respirators

Medical Evaluation Request

1. Today's date _____
2. Your name _____
3. Your age (to nearest year) _____
4. DOB _____ Sex ☐ Male ☐ Female
5. Your height _____ feet _____ inches
6. Your weight _____ pounds
7. Your job title _____
8. A phone number where you can be reached by the health-care professional who reviews this questionnaire (include area code)
   _____
9. The best time to phone you at this number _____
10. Check the type of respirator you will use (check all that apply)
    - ☐ N-, R-, or P-disposable respirator (f lter-mask, non-cartridge type only)
    - ☐ Half face-piece type
    - ☐ Full face-piece type
    - ☐ Powered air-purifying respirator (PAPR) – tight-f tting
    - ☐ PAPR – loose-f tting
    - ☐ Other type (supplied-air or self-contained breathing apparatus)
11. Have you worn a respirator? ☐ Yes ☐ No
    If "yes", what types? _____

Questionnaire for Users of N95 Respirators

Yes	No	
☐	☐	1. Do you currently or have you smoked tobacco during the previous month? If "yes"
		a. At what age did you start smoking? _____
		b. How long ago did you quit smoking? _____
		c. How many packs per day did or do you smoke?_____
		2. Have you ever had any of the following conditions?
☐	☐	a. Seizures
☐	☐	b. Diabetes
☐	☐	c. Allergic reactions that interfere with your breathing
☐	☐	d. Claustrophobia (fear of closed-in places)
☐	☐	e. Trouble smelling odors
		3. Have you ever had any of the following pulmonary or lung problems?
☐	☐	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 have been told about
		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 quickly 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 primarily 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 might be related to lung problems
		5. 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 have been told about
		6. Have you ever had any of the following cardiovascular or heart problems?
☐	☐	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 previous 2 years, have you noticed your heart skipping or missing a beat?
☐	☐	e. Heartburn or indigestion that is not related to eating
☐	☐	f. Any other symptom that you think might be related to heart or circulation problems
		7. Do you currently take any medications for any of the following problems?
☐	☐	a. Breathing or lung problems
☐	☐	b. Heart trouble
☐	☐	c. Blood pressure
☐	☐	d. Seizures
		8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check here ☐ 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. Are you currently taking any medications? If yes, list here
		_____
		_____
		_____
		_____
☐	☐	10. Would you like to talk with the health-care professional who will review this questionnaire about your answers to this questionnaire?

Please explain "yes" answers (use back of form if necessary)

_____

_____

_____

_____

For OHS Use Only, to be completed by OHS Clinician

Name: _____

PSEmployeeID: _____

☐ Cleared Without Restrictions for ☐ N95 ☐ PAPR

☐ Cleared With Restrictions for ☐ N95 ☐ PAPR

Recommended Frequency of Use (check the appropriate frequency on each line):

☐ 0 - 5 Hrs/Week ☐ 6 - 20 Hrs/Week ☐ > 20 Hrs/Week

☐ < 30 Minutes/Use At Once ☐ 30 - 60 Minutes/Use At Once ☐ > 60 Minutes/Use At Once

Restrictions:

Re-screening Frequency:

☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years

☐ No re-screening necessary unless health changes

☐ Requires PE/PFTs Per Protocol Prior To Clearance Determination (see PE sheet for additional determination)

☐ Not Approved

☐ Pending PCP or Treating Specialist Recommendation: Date of request _____

☐ Pending OHS Physician Review

☐ Smoking Cessation Materials To Be Sent

☐ Check That Employee Is Member Of HAZMAT Team

Comments (Additional History, Status of Physician Recommendation/Review):

_____

OHS Reviewer

_____

Date