PACIFIC LUTHERAN UNIVERSITY

Appendix D: School of Nursing Respirator Medical Evaluation Questionnaire

Name (last)				**(first)**	**(M.I.)**	**Today's date**
Phone				Clinical placement role		
Age	Sex	Height	Weight	Would you like to talk to the health care professional who will review this questionnaire about your answers? (circle one) **Yes** **No**		
Have you ever worn a respirator? (circle one) **Yes** **No**				If you have, what type(s) of respirator?		

Circle Yes or No for each of the questions below:

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?				Yes / No
2. Have you ever experienced any of the following?				
a. Seizures	Yes / No	b. Diabetes		Yes / No
c. Trouble smelling odors	Yes / No	d. Claustrophobia		Yes / No
e. Allergic reaction that affected your breathing				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. Lung Cancer		Yes / No
i. Pneumothorax	Yes / No	j. Broken Ribs		Yes / No
k. Chest injuries or surgeries	Yes / No	l. Any other lung problem you are aware of?		Yes / No
4. Do you *currently have* any of the following symptoms of pulmonary or lung illness?				
a. Shortness of breath (in general)	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 washing or dressing self	Yes / No	d. Shortness of breath when walking with other people at an ordinary pace on level ground		Yes / No
e. Shortness of breath that interferes with your job	Yes / No	f. Have to stop for breath when walking at your own pace on level ground		Yes / No
g. Coughing that produces phlegm	Yes / No	h. Coughing that wakes you early in the morning		Yes / No

This document, when completed, is considered confidential protected health information and must be filed in a secure location.

Appendix D: School of Nursing Respirator Medical Evaluation Questionnaire

i.	Coughing that occurs mostly when lying down	Yes / No	j.	Wheezing or wheezing that interferes with your job	Yes / No
k.	Coughing up blood in the last month	Yes / No	l.	Chest pain when breathing deeply	Yes / No
m.	Any other symptoms that you think may 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.	Swelling in legs or feet (not caused by walking)	Yes / No
c.	Stroke	Yes / No	d.	High blood pressure	Yes / No
e.	Heart failure	Yes / No	f.	Heart arrythmia	Yes / No
g.	Angina	Yes / No	h.	Any other heart problems that you have been told about	`
6.	Have you ever had any of the following cardiovascular or heart symptoms?				
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, your heart skipping or missing a beat	Yes / No
e.	Heartburn or indigestion that is not related to eating	Yes / No	f.	Any other symptoms that you feel may be related to heart or circulation problems	Yes / No
7.	Do you currently take medication for any of the following conditions?				
a.	Heart trouble	Yes / No	b.	Breathing or lung problem	Yes / No
c.	Seizures	Yes / No	d.	Blood pressure	Yes / No
8.	If you've used a respirator, have you ever had any of the following problems?				
a.	Eye irritation	Yes / No	b.	Skin allergies or rashes	Yes / No
c.	Anxiety	Yes / No	d.	General weakness/fatigue	Yes / No
e.	Any other problem that interferes with respirator use				Yes / No

Health care provider's instructions:

Follow-up evaluation is required for **any** positive response to questions 1-8. This might include phone consultations to evaluate positive responses, medical tests, and diagnostic procedures.

If you **cannot** confirm at this time that the student is able to safely wear a respirator, that student should be placed in a clinical location that does not require respiratory protection.

Is this person able to safely wear a respirator for their clinical placement?	**Yes / No**
Name of health care provider:	Date:

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