



Respirator Medical Evaluation Questionnaire

Student Version

Employee Occupational Health

Ph: 612-262-4490

RETURN COMPLETED FORM TO: sniocchealth@allina.com

Student Name: _____ Last, First & MI

Student Allina Health "A" Number: _____ Date of Birth: _____

Student Role: _____ School Name: _____

Daytime Phone: _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Have you worn a respirator? Yes No

If yes, what type? _____

Do you currently have a beard or other facial hair? Yes No

Mandatory Questions 1-9, for any Student Selected to Use a Respirator	Yes	No
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?		
2. Have you ever had any of the following conditions?		
a) Seizures?		
• When was your last seizure?		
• Are seizures controlled with meds?		
b) Diabetes (sugar disease) Type 1 _____ ; Type 2 _____		
• Is your diabetes stable?		
• Have you ever had complications?		
c) Allergic reactions that interfere with your breathing? (describe below)		
d) Claustrophobia (fear of closed-in places)? (describe below)		
Do you have problems wearing masks?		
e) Trouble smelling odors?		
<i>If you have answered Yes to any above, please explain</i>		
3. Have you ever had any of the following pulmonary or lung problems recently or within the past 12 months?	Yes	No
a) Asbestosis?		
b) Asthma (allergy or exercise induced?) Please circle		
c) Chronic bronchitis?		
d) Emphysema?		
e) Pneumonia? (Enter date)		
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?		
<i>If you have answered Yes to any of the questions 1-9, please explain</i>		
4. Do you currently have any of the following symptoms of pulmonary or lung illness?	Yes	No
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 hampers your job?		
g) Coughing that produces thick sputum or productive cough more than 3 months a year?		
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?		

If you answered yes, have you been evaluated by PMD, and do you have a diagnosis?) Please explain.

5. Have you ever had any of the following cardiovascular or heart problems recently or within the past 12 months?	Yes	No
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? You must enter current BP here:		
h) Any other heart problem that you've been told about?		

If you answered Yes to any of the above, please explain.

6. Have you ever had any of the following cardiovascular or heart symptoms:	Yes	No
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?		

If you answered Yes to any of the above, please explain.

7. Do you currently take medication for any of the following problems:	Yes	No
a) Breathing or lung problems?		
b) Heart trouble?		
c) Blood pressure?		
d) Seizures?		

If you answered Yes to any of the above, please explain.

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, go to question 9).			Yes	No
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?				
<i>If you answered Yes to any of the above, please explain.</i>				
9. Would you like to talk to the health care professional who will review this questionnaire about any of your answers to these questions?			Yes	No
<i>Comments:</i>				

Student Signature _____ Date _____
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