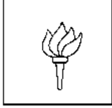

NEW YORK UNIVERSITY
Respirator Medical Evaluation Questionnaire
Modified for NYU Dentistry Use June 2020

To the employee: Can you read English: Yes ( ) No ( )
You will be allowed to answer this questionnaire during normal working hours, or at a time and place that is convenient to you**. To maintain confidentiality, please upload to the NYU Box folder that has been shared with you at the following link. General questions about this form can be directed to Environmental Health & Safety by calling 212-998-1450.**

A nurse practitioner at the New York University College of Dentistry will review this form. **Any questions or concerns regarding the questions may be directed to Yvelande Couamin (yc73@nyu.edu) at 212-998-9727.**

Part A

Section 1. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Date:__________________________

Name: [Print]____

Age:___________________ Date of Birth:__________________________

Gender: Male ( ) Female ( ) Employee/Student Net ID.:________________________________

Height: __________ ft. __________ in.

Weight: ____________ lbs.

Position/Title: ____

Department: ____

Phone Number: [Work]______________________________
[Home}______________________________
[Cell]_______________________________

Since you last respirator clearance, have there been any changes in your health?
Yes ( ) No ( ) First time filling out questionnaire ( )

Has the employer told you how to contact the health care professional who will review this questionnaire?
Yes ( ) No ( )

Check the type of respirator to be used (more than one category can be checked):
a. ______ N, R, or P disposable filter respirator
b. ______ Half- or full-face air purifying respirator with cartridges
c. _______Self-contained breathing apparatus

Name: [Print]____

Have you worn a respirator: Yes ( ) No ( )

If "yes," what type(s):
____
____
____

If "yes", when?____

Section 2. Every employee selected to use any type of respirator must answer questions 1 through 9 below.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month:
Yes ( ) No ( )

2. Have you ever had any of the following conditions?

a. Seizure disorder or a neurological illness
Yes ( ) No ( )

b. Diabetes (sugar disease)
Yes ( ) No ( )

c. Allergic reactions that interfere with breathing
Yes ( ) No ( )

d. Claustrophobia (fear of closed-in places)
Yes ( ) No ( )

e. Trouble sensing odors
Yes ( ) No ( )

3. Have you ever had any of the following pulmonary (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. Pneumothorax (collapsed lung)
Yes ( ) No ( )

i. Lung cancer
Yes ( ) No ( )

j. Broken ribs
Yes ( ) No ( )

k. Any chest injuries or surgeries
Yes ( ) No ( )

l. Any other lung problem not listed
Yes ( ) No ( )

Name: [Print]____

4. Do you currently have any of the following symptoms of pulmonary illness?

a. Shortness of breath
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 walking with other people at an ordinary pace on level ground
Yes ( ) No ( )

d. Have to stop for breath when walking at your own pace on level ground
Yes ( ) No ( )

e. Shortness of breath when washing or dressing yourself
Yes ( ) No ( )

f. Shortness of breath that interferes with your job
Yes ( ) No ( )

g. Coughing that produces phlegm (thick sputum)
Yes ( ) No ( )

h. Coughing that wakes you early in the morning
Yes ( ) No ( )

i. Coughing that occurs mostly when you are lying down
Yes ( ) No ( )

j. Coughing up blood with in the last month
Yes ( ) No ( )

k. Wheezing
Yes ( ) No ( )

l. Wheezing that interferes with your job
Yes ( ) No ( )

m. Chest pain when you breathe deeply
Yes ( ) No ( )

n. 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. Stroke
Yes ( ) No ( )

c. Angina
Yes ( ) No ( )

d. Heart failure
Yes ( ) No ( )

e. Swelling in your legs or feet (not caused by walking)
Yes ( ) No ( )

f. Heart arrhythmia (heart beating irregularly)
Yes ( ) No ( )

g. High blood pressure
Yes ( ) No ( )

h. Any other heart problem that you've been told about
Yes ( ) No ( )

Name: [Print]____

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, have you noticed 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 think may be related to heart or circulation problems
Yes ( ) No ( )

7. Do you currently take medication for any of the following problems?

a. Breathing or lung problems
Yes ( ) No ( )

b. Heart trouble
Yes ( ) No ( )

c. Blood pressure
Yes ( ) No ( )

d. Seizure disorder or neurological illness
Yes ( ) No ( )

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)**

a. Eye irritation
Yes ( ) No ( )

b. Skin allergies or rashes
Yes ( ) No ( )

c. Anxiety
Yes ( ) No ( )

d. General weakness or fatigue
Yes ( ) No ( )

e. Any other problem that interferes with your use of a respirator
Yes ( ) No ( )

9. Would you like to talk to the health care professional that will review this questionnaire about your answers to this questionnaire?
Yes ( ) No ( )

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). **For employees who have been selected to use other types of respirators, answering these questions is voluntary.**

10. Have you ever lost vision in either eye (temporarily or permanently)?
Yes ( ) No ( )

Name: [Print]____

11. Do you currently have any of the following vision problems?

a. Wear contact lenses

Yes ( ) No ( )

b. Wear glasses

Yes ( ) No ( )

c. Color blind

Yes ( ) No ( )

d. Any other eye or vision problem

Yes ( ) No ( )

12. Have you ever had an injury to your ears, including a broken eardrum?

Yes ( ) No ( )

13. Do you currently have any of the following hearing problems?

a. Difficulty hearing

Yes ( ) No ( )

b. Wear a hearing aid

Yes ( ) No ( )

c. Any other hearing or ear problem

Yes ( ) No ( )

14. Have you ever had a back injury?

Yes ( ) No ( )

15. Do you currently have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet

Yes ( ) No ( )

b. Back pain

Yes ( ) No ( )

c. Difficulty fully moving your arms and legs

Yes ( ) No ( )

d. Pain or stiffness when you lean forward or backward at the waist

Yes ( ) No ( )

e. Difficulty fully moving your head up or down

Yes ( ) No ( )

f. Difficulty fully moving your head side to side

Yes ( ) No ( )

g. Difficulty bending at your knees

Yes ( ) No ( )

h. Difficulty squatting to the ground

Yes ( ) No ( )

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs

Yes ( ) No ( )

j. Any other muscle or skeletal problem that interferes with using a respirator

Yes ( ) No ( )

Name: [Print]____

Part B

The following questions will give additional information to the physician. Most of the questions may not be applicable to you, however, answer all that do apply.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?

Yes ( ) No ( )

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions?

Yes ( ) No ( )

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?

Yes ( ) No ( )

3. Have you ever worked with any of the materials listed below?

a. Asbestos
Yes ( ) No ( )

b. Silica (e.g., in sandblasting)
Yes ( ) No ( )

c. Tungsten/cobalt (e.g., grinding or welding this material)
Yes ( ) No ( )

d. Beryllium
Yes ( ) No ( )

e. Aluminum
Yes ( ) No ( )

f. Coal (for example, mining)
Yes ( ) No ( )

g. Iron
Yes ( ) No ( )

h. Tin
Yes ( ) No ( )

i. Dusty environments
Yes ( ) No ( )

j. Any other hazardous exposures
Yes ( ) No ( )

4. List any second jobs or side businesses you have:____

5. List your previous occupations:____

6. List your current and previous hobbies:____

Name: [Print]____

7. Have you been in the military services?

Yes ( ) No ( )

If "yes," were you exposed to biological or chemical agents (either in training or combat)?

Yes ( ) No ( )

8. Have you ever worked on a HAZMAT team?

Yes ( ) No ( )

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications):

Yes ( ) No ( )

10. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?

Yes ( ) No ( )

11. Will you be working under hot conditions (temperature exceeding 77 deg. F) ?

Yes ( ) No ( )

12. Will you be working under humid conditions?

Yes ( ) No ( )

FOR HSU USE ONLY:

Reviewed by: ____ Title: _________ Date: __________

Reviewer's Comments:

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