Infectious Agent – Isolation Containment

JOHNS HOPKINS HEALTH, SAFETY AND ENVIRONMENT:
MEDICAL EVALUATION QUESTIONNAIRE

The following questionnaire is part of the OSHA's requirement for respiratory protection. The questionnaire will be delivered to Occupational Health Services for evaluation. If there is need for Occupational Health Services will contact you. If you need to contact Occupational Health Services their numbers are:

East Baltimore	410 955-6211
Homewood	410 516-0450

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).

Today's date: ________________________________

Your name:__________________________________ Badge ID # __________________________________

Your age (to nearest year): ____________________ Sex: ____ Male _____ Female

Your height: _____ ft. _____ in. Your weight: _____ lbs.

Your job title: ____

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): ____

The best time to phone you at this number: _____________________________

Check the type of respirator you will use (you can check more than one category):

____ N, R, or P disposable respirator (filter-mask, non cartridge type only).

____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator Yes No

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

Part A. Section 2. Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no")

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. Seizures (fits) Yes No
   b. Diabetes (sugar disease) Yes No
   c. Allergic reactions that interfere with your breathing Yes No
   d. Claustrophobia (fear of closed-in places) Yes No
   e. Trouble smelling odors: 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. 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 that you've been told about Yes No

4. Do you currently have any of the following symptoms of pulmonary or lung 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 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

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.	Seizures (fits)	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, please circle "yes" or "no" and 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. 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

   If "yes", name the medication if you know them: ____________________

10. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes No