Patient Label
Patient Name
DOB

Stanford MEDICINE

Annual Respirator Medical Evaluation Questionnaire

Stanford University SOM

The following information must be provided by every health care worker who has been selected to use any type of respirator

Name (Last, First):	DOB:	Today's Date:
Phone:	Place of Work:	

Would you answer 'yes' to any of the questions below? □ Yes □ No
(If 'No', then skip the questions below and proceed to sign/date at the bottom of the form)

1. Have you experienced any of the following pulmonary or lung problems since your last fit test?	
Asbestosis/Tuberculosis/Silicosis/Pneumothorax (collapsed lung)/Lung cancer	□ Yes □ No
Broken Ribs/Any chest injuries/surgery	□ Yes □ No
2. Do you currently have any of the following symptoms of pulmonary or lung illness?	
Shortness of Breath/Shortness of breath when walking, washing or dressing yourself, that interferes with your job	□ Yes □ No
Coughing that produces phlegm (thick sputum), wakes you early in the morning, occurs mostly when you are lying down, or results in coughing up blood	□ Yes □ No
Wheezing/Wheezing that interferes with your job	□ Yes □ No
Chest pain when you breathe deeply	□ Yes □ No
Any other symptoms that you think may be related to lung problem	□ Yes □ No
3. Have you experienced any of the following cardiovascular or heart problems since your last fit test?	
Heart attack	□ Yes □ No
Stroke	□ Yes □ No
Angina	□ Yes □ No
Heart failure	□ Yes □ No
Swelling in legs/feet (not caused by walking)	□ Yes □ No
Heart arrythmia (heart beating irregularly)	□ Yes □ No
High blood pressure	□ Yes □ No
Any other heart problems that you have been told about	□ Yes □ No
4. Do you currently have any of the following symptoms of cardiovascular or heart problems?	
Pain or tightness in your chest/pain or tightness in your chest during physical activity/pain or tightness that interferes with your work	□ Yes □ No
Your heart skips or misses a beat	□ Yes □ No
Heartburn or indigestion that is not related to eating	□ Yes □ No
Any other symptoms that you think may be related to heart or circulation problems	□ Yes □ No
5. Are you currently taking any new medication(s) since your last respirator medical evaluation?	□ Yes □ No
Please name the medications if you know them: _____	
6. Have you experienced any of the following problems while using a respirator?	□ Yes □ No
Eye irritation	□ Yes □ No
Skin allergies or rashes	□ Yes □ No
Anxiety	□ Yes □ No
General weakness or fatigue	□ Yes □ No
Any other problem that interferes with the use of a respirator	□ Yes □ No
7. Would you like to speak with a health care professional who will review this questionnaire?	□ Yes □ No

I certify that the provided information is complete and true to the best of my knowledge.

Signature:_____ **Date:** ____ /____ /_____

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TO BE COMPLETED BY THE CLINIC ONLY

To Be Completed by the Clinician Reviewing the Form	
Medical Clearance for use of an N95 respirator in a clinical care setting:	
☐ Approved	
☐ Approved with restrictions: _____	
☐ Denied	
WHW Clinician Name: _____	
WHW Clinician Signature: _____	*Date:*

To Be Completed by the Fit Tester					
What Fit Test was performed?			○ Quantitative by PortaCount [ ]	○ Qualitative	
Qualitative Fit Test Agent			○ Sacchrin	○ Bitrex	
Has this individual passed the Fit Test?			□ Yes	□ No	□ Facial hair
Mask Model:	□ 3M 1860	□ 3M 1860S	□ 3M 1870+	□ Halyard 46827	□ MediShield
□ Other: _____					
☐ This person needs to complete the HealthStream module for CAPR			**CAPR Training can be found within HealthStream Course:** *Search "Stanford Medical – Respirator Protective Protocol"*		
Fit Tester Name:					
Fit Tester Signature: _____			Fit Test Date:		