Baylor College of Medicine

Respirator Questionnaire for TB mask
Baylor Occupational Health Program

Fax 713-798-3364 scv_auto_print@bcm.edu

Section I: Employee Information (please print)

Name: _____ BCM ID (if known): _____
Last First MI

Date of Birth: _____ Age: _____ Phone Number: _____

Section II: Respirator/Work Information (Check all that apply)

DURATION OF RESPIRATOR USE:
✓ Only during patient care activities
___Only during emergency situations
___Regularly, but less than 5 hrs./week
___Over 1 hour per day every day

LEVEL OF EXERTION DURING RESPIRATOR USE:
✓ Light (mainly sedentary work, no lifting)
___Moderate (lifting up to 20 pounds occasionally)
___Heavy (carrying over 20 pounds or climbing frequently)

Section III: Medical History / Symptom Review

Do you have or have you ever had any of the following medical conditions?

___Heart Attack or angina
___Heart arrhythmias
___Other heart disease:
_____
___Stroke
___Asthma (if yes, indicate if condition is active and how frequently you use medication)
_____
___Tuberculosis
___Emphysema/Chronic bronchitis (with symptoms
___Pneumothorax (lung collapse)
___Any surgery or serious injury to the chest
___Pneumonia (if yes, when _____)
___Other lung disease _____
_____
___Anemia
___Skin allergies or rashes (if yes, substance _____)

Do you have or have you had any of the following problems? Please check any symptoms which you think are <u>out of the ordinary.</u>

___Shortness of breath
___Persistent cough (outside of colds)
___Wheezing (outside of colds)
___Persistent chest pains
___Palpitations or skipped heart beats
___Loss of consciousness

Are you taking any medications? _____Yes _____No
If yes, please list _____

Have you smoked within the last 30 days? _____Yes ____No
Have you ever worn a respirator before _____Yes ____No
If yes and you had problems with respirator use, please explain:
_____

I understand that the above information is used to determine my ability to wear a respirator for protection from tuberculosis. The information I have furnished is true to the best of my knowledge. If I experience a significant change in my health status, I will notify Baylor Occupational Health..

Signature _____ Date_____

OHP use: Reviewer _____ ____ Y ____N Date_____