UNIVERSITY OF COLORADO SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION (GME)
Program for Resident Occupational Health (PROHealth)
(PROHealth@dhha.org; Phone: 303-602-4774; Fax: 303-436-5407)

IMMUNIZATION SUMMARY

INSTRUCTIONS FOR IMMUNIZATION SUMMARY & SUPPORTING DOCUMENTATION:
After you have completed the form, save and upload it and your supporting documentation to the Immunization Summary and Supporting Documentation area in MedHub. This information will be forwarded to our practitioner for review to determine services for your upcoming immunization screening and mask fit. Keep your original immunization information as you will need your records in the future.

Today's Date _____/_____/_____

Name
Last _____ First _____ Middle _____

Street Address (or P.O. Box) _____

City_____ State_____ Zip Code _____

Phone _____ Email Address_____

Date of Birth _____ /_____ /_____

Training Program _____

Last Four Digits of SSN: _____

Name_____ **Program**_____

TB RESPIRATOR FIT PROGRAM QUESTIONNAIRE

If you have already been fitted for an N95 respirator mask, have not had a weight gain or loss greater than 10 pounds since being tested, and have documentation that shows your mask size, please scan and upload documentation to the Immunization Summary and Supporting Documentation area in MedHub. You do not need to complete the TB RESPIRATOR FIT PROGRAM QUESTIONNAIRE or be retested.

Otherwise, please proceed with completing both pages of this form.

	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	❑	❑
b. Diabetes	❑	❑
c. Allergic reactions that interfere with your breathing	❑	❑
d. Claustrophobia	❑	❑
e. Trouble smelling odors	❑	❑
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis	❑	❑
b. Asthma	❑	❑
c. Chronic bronchitis	❑	❑
d. Emphysema	❑	❑
e. Pneumonia	❑	❑
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	❑	❑
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
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 interferes with work	❑	❑
g. Coughing that produces phlegm	❑	❑
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 work	❑	❑
m. Chest pain when you breathe deeply	❑	❑
n. Any other symptoms that you think may be related to lung problems	❑	❑

Name_____ **Program**_____

5. Have you ever had any of the following cardiovascular or heart problems?

a. Heart attack	❑	❑
b. Stroke	❑	❑
c. Angina	❑	❑
d. Heart failure	❑	❑
e. Swelling in your legs or feet (not caused by walking)	❑	❑
f. Heart arrhythmia	❑	❑
g. High blood pressure	❑	❑
h. Any other heart problem that you've been told about	❑	❑

6. Have you ever had any of the following cardiovascular or heart symptoms?

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 work	❑	❑
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	❑	❑

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

a. Breathing or lung problems	❑	❑
b. Heart trouble	❑	❑
c. Blood pressure	❑	❑
d. Seizures	❑	❑

8. If you've used a respirator, have you ever had any of the following problems?
(If you've never used a respirator, proceed to question 9)

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	❑	❑

9. Would you like to talk to the health care professional who will review this questionnaire about the answers you have given? ❑ ❑

EXPLAIN ALL "YES" ANSWERS.

Respirator Fit Testing: ____Approved ____Not Approved ____Med Eval Required
Reviewer's comments:

_____ _____
Signature of reviewer Date
TB Respirator Fit Program Questionnaire

COLOR TEST INTERPRETATION FORM

CLINICAL TESTS REQUIRING COLOR INTERPRETATION

Certain tests, such as those listed below, are visually read and require color differentiation for accurate interpretation:

-Fecal Occult Blood
-Gastric Occult Blood
-Urine Dipstick
-pH by Nitrazine Paper

Please select the option below that applies to you.

- ❑ **I certify that I am NOT colorblind.**
- ❑ **I am colorblind and agree that I cannot interpret clinical tests that require color differentiation.**
- ❑ **I do not know if I am colorblind and would like to be tested. I understand I am not to interpret clinical tests that require color differentiation if I am colorblind.**

Please read the below disclosure and check the box if you agree.

☐ In the event of a work related exposure, I hereby grant PROHealth authorization to release my immunization and screening information directly to the entity where the exposure occurred.

☐ **REQUIRED BOX**

By checking this box, I acknowledge that all the information provided on the Immunization Summary, TB Respirator Fit Questionnaire, Color Test Interpretation form and supporting documentation is true and correct to the best of my knowledge.

Name: _____ _____ **Program**: _____

Last Name First Name

Date: _____