

**Initial Medical Questionnaire for Respirator Use
Occupational Medicine Program**

Part A Section 1

Date: _____
 Name: _____ UFID: _____ Date of Birth: _____
 Sex (circle one): Male/Female Weight: _____ Height: _____
 Position (Title): _____ Best time to reach you: _____
 Phone number where the reviewer can reach you: _____

Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): yes / no

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-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you ever worn a respirator (circle one): yes/no
 If "yes," what type(s): _____

Part A Section 2

| | Yes | No |
|--|--------------------------|--------------------------|
| 1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had any of the following conditions: | | |
| a. Seizures (fits) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Diabetes (sugar disease) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Allergic reactions that interfere with breathing | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Claustrophobia (fear of closed-in places) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Trouble smelling odors | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had any of the following pulmonary or lung problems: | | |
| a. Asbestosis | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Chronic bronchitis | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Silicosis | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Pneumothorax (collapsed lung) | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Lung cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Broken ribs | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Any chest surgeries | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Any other lung problem you have been told about | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 4. Do you currently have any of the following symptoms: | | |
| a. Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath when walking with other people at an ordinary pace on level ground | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have to stop for breath when walking at your own pace on level ground | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Shortness of breath when washing or dressing yourself | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Shortness of breath that interferes with your job | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Coughing that produces phlegm (thick sputum) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Coughing that wakes you early in the morning | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Coughing that occurs mostly when you are lying down | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Coughing up blood in the last month | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Wheezing | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Wheezing that interferes with your job | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Chest pain when you breathe deeply | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Any symptoms you think may be related to lung problems | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 5. Have you ever had any of the following cardiovascular or heart problems: | | |
| a. Heart attack | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Angina | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Heart failure | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Swelling in your legs or feet (not caused by walking) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Heart arrhythmia (heart beating irregularly) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Any other heart problem you've been told about | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 6. Have you ever had any of the following symptoms: | | |
| a. Frequent pain or tightness in your chest | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Pain or tightness in your chest during physical activity | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Pain or tightness in your chest that interferes with your job | <input type="checkbox"/> | <input type="checkbox"/> |
| d. In the past two years, have you noticed your heart skipping or missing a beat | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Heartburn or indigestion that isn't related to eating | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Any other symptoms that you think may be related to heart or circulation problems | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 7. Do you currently take medication for any of the following problems: | | |
| a. Breathing or lung problems | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Seizures | <input type="checkbox"/> | <input type="checkbox"/> |

- | | 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 skip to question 9): | | |
| a. Eye irritation | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Skin allergies or rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| d. General weakness or fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Any other problem that interferes with your use of a respirator | <input type="checkbox"/> | <input type="checkbox"/> |

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: yes/ no

***Questions 10 to 15 must be answered by every employee who has been selected to use either a full-facepiece 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.**

- | | Yes | No |
|--|--------------------------|--------------------------|
| 10. Have you ever lost vision in either eye (temporarily or permanently): | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you currently have any of the following vision problems: | | |
| a. Wear contact lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear glasses | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Color blind | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Any other eye or vision problem | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had an injury to your ears, including a broken ear drum: | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you currently have any of the following hearing problems: | | |
| a. Difficulty hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear a hearing aid | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any other hearing or ear problem | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a back injury: | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 15. Do you currently have any of the following musculoskeletal problems | | |
| a. Weakness in any of your arms, hands, legs, or feet | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Back pain | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Difficulty fully moving your arms and legs | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pain or stiffness when you lean forward or backward at the waist | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Difficulty fully moving your head up or down | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Difficulty fully moving your head side to side | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Difficulty bending at your knees | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Difficulty squatting to the ground | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs. | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Other muscular or skeletal problem that interferes with using respirator | <input type="checkbox"/> | <input type="checkbox"/> |

Part B

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health professional who will review the questionnaire.

1. 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
 If "yes," name the chemicals if you know them: _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 2. Have you ever worked with any of the materials or under any of the conditions, listed below: | | |
| a. Asbestos | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Silica (e.g. in sandblasting) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Tungsten/cobalt (e.g., grinding or welding this material) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Beryllium | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Aluminum | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Coal (for example, mining) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Iron | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Tin | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Dusty environments | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Any other hazardous exposures | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes," describe these exposures: _____ | | |

3. List any second jobs or side businesses you have : _____
4. List your previous occupations: _____
5. List your current and previous hobbies: _____

6. 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
7. Have you ever worked on a HAZMAT team: yes / no
8. Other than medications for 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 medications and the condition they are for:

9. Will you be wearing protective clothing and/or equipment (other than the respirator) when you’re using your respirator: yes / no
If “yes,” describe this protective clothing and/or equipment: _____

10. Will you be working under hot conditions (temperature exceeding 77 F): yes / no

11. Will you be working under humid conditions: yes / no

12. Describe the work you’ll be doing while you’re using your respirator(s):

13. Describe any special or hazardous conditions you might encounter when you’re using your respirator(s) (for example, confined spaces, life-threatening gases):

14. Describe any special responsibilities you’ll have while using your respirator(s) that may affect the
Safety and well-being of others (for example, rescue, security):

Employee Signature

Date