



Name:		UF ID #:		Date of Birth:	
Height:		Weight:		Age:	
Position (Title):			LP#:		
Supervisor:			Department:		
Address:			Work Telephone Number:		
Describe any apparent difficulties noted with respirator use, if any:					
Have you had or do you now have any of the following:		Yes	Within the Last Year?	No	
1. Lung disease					
2. Persistent cough					
3. Shortness of breath					
4. History of fainting or seizures					
5. Heart Trouble					
6. Frequent pain / tightness in chest					
7. Heartburn/indigestion not related to eating					
8. High blood pressure					
9. Diabetes					
10. Fear of tight or enclosed places					
11. Sensation of smothering					
12. Heat exhaustion or heat stroke					
13. Ruptured ear drum					
14. Defective vision					
15. Defective hearing					
16. Wear contact lenses or glasses					
17. Other conditions that might interfere with respirator use or result in limited work ability					
18. Are you taking any medications (prescription or over-the-counter) If Yes, LIST:					
19. Do you currently smoke? If Yes, how many do you smoke per day?					
20. Have you had a significant medical or surgical problem since your last respirator evaluation?					
Please Explain Yes Answers:					
Employee's Signature:				Date:	
Physician Use Only					
<input type="checkbox"/> No Restriction on Respirator Use			<input type="checkbox"/> Further Evaluation Needed		
Physician's Review Signature:				Date:	