

The information requested on these pages is necessary in order to minimize any occupational risks to you and to insure that you can safely perform the essential functions of your new job.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

Must complete ALL sections.

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (Mm / dd / yy)

UF ID #: _____ **Gender at Birth:** **Male** **Female**

Email Address: _____ **Cell number:** _____

Address: _____

City, State Zip: _____

Work Site: **Gainesville** **Jacksonville** **Other:** _____

Department: _____ **Supervisor/Program Director:** _____

Position Number: _____ **Job Title:** _____

Section I - Medical History

Do you have now, have you ever had, or have you received treatment for the following:

	Yes	No	If YES use as many lines below as needed to explain with dates.
Alcohol abuse/alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies to medications/foods	<input type="checkbox"/>	<input type="checkbox"/>	
Back or neck injury	<input type="checkbox"/>	<input type="checkbox"/>	
Carpal Tunnel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic back pain	<input type="checkbox"/>	<input type="checkbox"/>	
Current Medications: doses and Frequency	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes (type)	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty hearing/hearing aides	<input type="checkbox"/>	<input type="checkbox"/>	
Drug abuse/addiction	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalizations/Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	
Immunosuppression Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>	

	Yes	No	If YES use as many lines below as needed to explain
Latex allergy or other skin sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	
Other hand/wrist problems	<input type="checkbox"/>	<input type="checkbox"/>	
Other liver disease (type)	<input type="checkbox"/>	<input type="checkbox"/>	
Visual loss (one or both eyes)	<input type="checkbox"/>	<input type="checkbox"/>	

Have you ever had a work-related illness or injury? Yes No

If yes, explain: _____

Have you been cleared by a medical provider to return to full duty without restrictions? Yes No

Date: _____

Are you currently recovering from any significant illness, surgery or injury? Yes No

If yes, explain: _____

Have you been cleared by a medical provider to return to full duty without restrictions? Yes No

Date: _____

Do you have any medical or psychological conditions that you feel may prevent you from completely and safely performing the duties outlined in your job description, or do you require/request any modifications to your job duties?

Yes No If yes, explain: _____

Would you like to speak to a UF Occupational Medicine clinician about any of the information you have given above?

Yes No If yes, daytime phone: _____

Print Name: _____ **UFID#:** _____

Signature: _____ **Date:** _____

Today's Date:				
Last Name:		First Name:		MI:
Phone:	Date of Birth:	Gender at Birth:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Job Title:	Height:	(ft)	(in)	Weight: (lbs)
Do you know how to contact the Healthcare professional who will review this?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Can you read English:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you exercise:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you worn a respirator in the past?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Physical exertion while wearing a respirator:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Medical Questionnaire

Do you <i>currently</i> smoke tobacco, or have smoked tobacco in the last month?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If "yes" to any of the following, how many packs per day?				
How many years have you smoked?				

Have you ever had any of the following conditions?

	YES	NO		YES	NO
Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>	Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reaction that interfere with your breathing				<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain:					

Have you ever had any of the following pulmonary or lung problems?

	YES	NO		YES	NO
Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>	Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Silicosis	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Any other lung problem you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
Please explain ALL Yes answers:					

Do you currently have any of the following symptoms of pulmonary or lung illness

	YES	NO		YES	NO
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath when walking with other people at ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	Have to stop for breath when walking at your own pace walking on level ground	<input type="checkbox"/>	<input type="checkbox"/>
Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>	Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>	Any other pulmonary/lung symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Please explain ALL Yes answers:					

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

	YES	NO		YES	NO
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in your legs not caused by walking	<input type="checkbox"/>	<input type="checkbox"/>

Please explain **ALL** Yes answers:

Have you ever had any of the following cardiovascular or heart symptoms:

	YES	NO		YES	NO
Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>	Skipping/missing heartbeat (in last 2 years)	<input type="checkbox"/>	<input type="checkbox"/>
Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn-like symptoms not related to eating	<input type="checkbox"/>	<input type="checkbox"/>
Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>	Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>

Please explain ALL Yes answers:

Do you currently take medications for any of the following?

	YES	NO		YES	NO
Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Seizure (fits)	<input type="checkbox"/>	<input type="checkbox"/>

Please explain ALL Yes answers:

If you've used a respirator, have you ever had any of the following problems while using a respirator?

	YES	NO		YES	NO
Eye Irritation:	<input type="checkbox"/>	<input type="checkbox"/>	General weakness or fatigue:	<input type="checkbox"/>	<input type="checkbox"/>
Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Any other problem that interferes with your use of a respirator				<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of above, please explain:

Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? YES NO

Additional comments:

To the best of my knowledge, the information I have provided is true and accurate.

Employee/Volunteer Signature: _____ Date: _____ Submit Button

OCCMED CLINIC USE ONLY
TO BE COMPLETED BY EXAMINER/REVIEWER

- The mandatory questionnaire has been reviewed.
- The Employee/Volunteer has been found to be physically able to use Single use, filter mask (four attachment points) N95 or PAPR.
- PAPR Only
- There is insufficient information to make a determination at this time.
- This Employee/Volunteer has been found to be physically NOT able to use a respirator.

Reviewer's Name (print) _____ Reviewer's Signature _____ Date _____

