

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 / yyyy)

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	☐	☐	
Allergies to medications/foods	☐	☐	
Back or neck injury	☐	☐	
Carpal Tunnel syndrome	☐	☐	
Chronic back pain	☐	☐	
Current Medications: doses and Frequency	☐	☐	
Diabetes (type)	☐	☐	
Difficulty hearing/hearing aides	☐	☐	
Drug abuse/addiction	☐	☐	
Hospitalizations/Surgeries	☐	☐	
Immunosuppression	☐	☐	
Infectious Disease	☐	☐	

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

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:	☐ Male	☐ Female
Job Title:		Height:	(ft) (in)	Weight: (lbs)
Do you know how to contact the Healthcare professional who will review this?		☐ Yes	☐ No	
Can you read English:		☐ Yes	☐ No	
Do you exercise:		☐ Yes	☐ No	
Have you worn a respirator in the past?		☐ Yes	☐ No	
Physical exertion while wearing a respirator:		☐ Yes	☐ No	

Medical Questionnaire

Do you <i>currently</i> smoke tobacco, or have smoked tobacco in the last month?		☐ Yes	☐ 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	
Seizures (fits)	☐	☐	Claustrophobia (fear of closed-in places)
Diabetes (sugar disease)	☐	☐	Trouble smelling odors
Allergic reaction that interfere with your breathing			
If yes, please explain:			
Have you ever had any of the following pulmonary or lung problems?			
	YES	NO	
Asbestosis	☐	☐	Pneumothorax (collapsed lung)
Asthma	☐	☐	Lung Cancer
Chronic bronchitis	☐	☐	Broken ribs
Emphysema	☐	☐	Any chest injuries or surgeries
Pneumonia	☐	☐	Silicosis
Tuberculosis	☐	☐	Any other lung problem you've been told about
Please explain ALL Yes answers:			
Do you currently have any of the following symptoms of pulmonary or lung illness			
	YES	NO	
Shortness of breath	☐	☐	Shortness of breath that interferes with your job
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	☐	☐	Shortness of breath when walking with other people at ordinary pace on level ground
Shortness of breath when washing or dressing yourself	☐	☐	Have to stop for breath when walking at your own pace walking on level ground
Coughing that produces phlegm (thick sputum)	☐	☐	Coughing that wakes you early in the morning
Coughing that occurs mostly when you are lying down	☐	☐	Coughing up blood in the last month
Wheezing	☐	☐	Chest pain when you breathe deeply
Wheezing that interferes with your job	☐	☐	Any other pulmonary/lung symptoms
Please explain ALL Yes answers:			

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

	YES	NO		YES	NO
Heart attack	☐	☐	Heart arrhythmia (heart beating irregularly)	☐	☐
Stroke	☐	☐	High blood pressure	☐	☐
Heart failure	☐	☐	Swelling in your legs not caused by walking	☐	☐

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	☐	☐	Skipping/missing heartbeat (in last 2 years)	☐	☐
Pain or tightness in your chest during physical activity	☐	☐	Heartburn-like symptoms not related to eating	☐	☐
Pain or tightness in your chest that interferes with your job	☐	☐	Any other symptoms that you think may be related to heart or circulation problems	☐	☐

Please explain ALL Yes answers:

Do you currently take medications for any of the following?

	YES	NO		YES	NO
Breathing or lung problems	☐	☐	Blood pressure	☐	☐
Heart trouble	☐	☐	Seizure (fits)	☐	☐

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:	☐	☐	General weakness or fatigue:	☐	☐
Skin allergies or rashes	☐	☐	Anxiety	☐	☐
Any other problem that interferes with your use of a respirator				☐	☐

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?	☐	☐
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Additional comments:

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

Employee/Volunteer Signature:

Date:

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

UF ID #: