UCSC Respirator User Medical Evaluation Questionnaire

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A do not require a medical examination. Send completed form through mail to Student Health Center c/o Cathy Sanders.

To the employee: Can you read (circle one): Yes / No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A

Section 1 (Mandatory)

The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date ______________________________
2. Your name ______________________________
3. Your Staff or Student Identification Number ______________________________
4. Your date of birth ______________________________
5. Your home address ______________________________
____
____
6. Your home phone number ______________________________
7. Your Gender ______________________________
8. Your height in feet and inches ______________________________
9. Your weight in pounds ______________________________
10. Your job title ______________________________
11. A phone number, including area code, where you can be reached by the health care professional who reviews this questionnaire
____
12. The best time to phone you at this number ______________________________
13. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one) Yes / No
You may contact a physician at The Campus Health Center by calling 459-2869
14. Check all respirator types you will use
   - ☐ N, R, or P Disposable Respirator (“dust mask”, filter-mask, non-cartridge type).
   - ☐ Half or Full-Face Negative Pressure Air Purifying Respirator
   - ☐ Powered Air Purifying Respirator
   - ☐ Supplied Airline Respirator
   - ☐ Self-Contained Breathing Apparatus (SCBA) Respirator

15. Have you worn a respirator (circle one): Yes / No
    If yes, what type(s) ______________________________
    ____

Section 2 (Mandatory)

Questions 1 – 17 are for every employee who will use a respirator. Circle yes or no.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes / No
2. Have you ever had any of the following conditions?
   - a Seizures (fits) Yes / No
   - b Diabetes (sugar disease) Yes / No
   - c Allergic reactions that interfere with your breathing Yes / No
   - d Claustrophobia (fear of closed-in places) Yes / No
   - e Trouble smelling odors Yes / No
3. Have you ever had any of the following pulmonary or lung problems?
   - a Asbestosis Yes / No
   - b Asthma Yes / No
   - c Chronic bronchitis Yes / No
   - d Emphysema Yes / No
   - e Pneumonia Yes / No
   - f Tuberculosis Yes / No
   - g Silicosis Yes / No
   - h Pneumothorax (collapsed lung) Yes / No
   - i Lung cancer Yes / No
   - j Broken ribs Yes / No
   - k Any chest injuries or surgeries Yes / No
   - l Any other lung problem that you've been told about Yes / No
4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   - a Shortness of breath Yes / No
   - b Shortness of breath when walking fast on level ground or walking up a slight hill or incline Yes / No
   - c Shortness of breath when walking with other people at an ordinary pace on level ground Yes / No
   - d Have to stop for breath when walking at your own pace on level ground Yes / No
   - e Shortness of breath when washing or dressing yourself Yes / No
   - f Shortness of breath that interferes with your job Yes / No
   - g Coughing that produces phlegm (thick sputum) Yes / No
   - h Coughing that wakes you early in the morning Yes / No
   - i Coughing that occurs mostly when you are lying down Yes / No
   - j Coughing up blood in the last month Yes / No
   - k Wheezing Yes / No
   - l Wheezing that interferes with your job Yes / No
   - m Chest pain when you breathe deeply Yes / No
   - n Any other symptoms that you think may be related to lung problems Yes / No

5. Have you ever had any of the following cardiovascular or heart problems?
   - a Heart attack — Yes / No
   - b Stroke — Yes / No
   - c Angina — Yes / No
   - d Heart failure — Yes / No
   - e Swelling in your legs or feet (not caused by walking) — Yes / No
   - f Heart arrhythmia (heart beating irregularly) — Yes / No
   - g High blood pressure — Yes / No
   - h Any other heart problem that you've been told about — Yes / No
6. Have you ever had any of the following cardiovascular or heart symptoms?
   - a Frequent pain or tightness in your chest — Yes / No
   - b Pain or tightness in your chest during physical activity — Yes / No
   - c Pain or tightness in your chest that interferes with your job — Yes / No
   - d In the past two years, have you noticed your heart skipping or missing a beat — Yes / No
   - e Heartburn or indigestion that is not related to eating — Yes / No
   - f Any other symptoms that may be related to heart or circulation problems — Yes / No
7. Do you currently take medication for any of the following problems?
   - a Breathing or lung problems — Yes / No
   - b Heart trouble — Yes / No
   - c Blood pressure — Yes / No
   - d Seizures (fits) — 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 — Yes / No
   - b Skin allergies or rashes — Yes / No
   - c Anxiety — Yes / No
   - d General weakness or fatigue — Yes / No
   - e Any other problem that interferes with your use of a respirator — Yes / No
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? — Yes / No
10. Do you currently have any of the following vision problems?
    - a Wear contact lenses — Yes / No
    - b Wear glasses — Yes / No
    - c Color blind — Yes / No
    - d Any other eye or vision problem — Yes / No
11. Have you ever had an injury to your ears, including a broken ear drum?
12. Do you currently have any of the following hearing problems?
    - a Difficulty hearing — Yes / No
    - b Wear a hearing aid — Yes / No
    - c Any other hearing or ear problem — Yes / No
13. Have you ever had a back injury? — Yes / No

14. Do you currently have any of the following musculoskeletal problems?
    - a Weakness in any of your arms, hands, legs, or feet — Yes / No
    - b Back pain — Yes / No
    - c Difficulty fully moving your arms and legs — Yes / No
    - d Pain or stiffness when you lean forward or backward at the waist — Yes / No
    - e Difficulty fully moving your head up or down — Yes / No
    - f Difficulty fully moving your head side to side — Yes / No
    - g Difficulty bending at your knees — Yes / No
    - h Difficulty squatting to the ground — Yes / No
    - i Climbing a flight of stairs or a ladder carrying more than 25 lbs — Yes / No
    - j Any other muscle or skeletal problem that interferes with using a respirator — Yes / No
15. How often are you expected to use the respirator?
    (circle "yes" or "no" for all answers that apply to you)
    - a Escape only (no rescue) — Yes / No
    - b Emergency rescue only — Yes / No
    - c Less than 5 hours per week — Yes / No
    - d Less than 2 hours per day — Yes / No
    - e 2 to 4 hours per day — Yes / No
    - f Over 4 hours per day — Yes / No
16. During the period you are using the respirator(s), is your work effort?
    - a Light (less than 200 kcal per hour) — Yes / No
      - (a) If yes, how many hours does this period last during the average shift? ___________
        Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.
    - b Moderate (200 to 350 kcal per hour) — Yes / No
      - (a) If yes, how many hours does this period last during the average shift? ___________
        Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
    - c Heavy (above 350 kcal per hour) — Yes / No
      - (a) If yes, how many hours does this period last during the average shift? ___________
        Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).
17. Will you be wearing protective clothing and/or equipment
    (other than the respirator) when you're using your respirator — Yes/No
    - a If yes, describe this protective clothing and/or equipment

Employee Name ______________________

College/Department ______________________

Supervisor ______________________

Campus Phone Number ______________________

Please Note:

To meet HIPPA requirements, there are only three ways to get this document to the Health Center:

1. Send to Cowell Student Health Center through campus mail c/o Health Information Management
2. FAX to (831) 459-3546
3. Hand deliver to the Health Center c/o Health Information Management

Below this line is for Health Center only

Cowell Student Health Center, please complete the following information, return a copy of this page to Risk Services (attention Respirator Program) and retain the original completed questionnaire with employee medical records.

Physician's Notes

This individual requires further medical evaluation Yes/No

This individual is medically certified to wear the following type(s) of respirators:

- ☐ N, R, or P Disposable Respirator ("dust mask", filter-mask, non-cartridge type only)
- ☐ Half or Full Face Negative Pressure Air Purifying Respirator
- ☐ Powered Air Purifying Respirator
- ☐ Supplied Airline Respirator
- ☐ Self Contained Breathing Apparatus (SCBA) Respirator

______________________ ______________________

Signature Date