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.

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. Staff or Student Identification Number: _____
4. Your date of birth: _____
5. Your home address: _____
   _____
   _____
6. Your home phone number: _____
6. Sex (circle one): Male/Female
7. Your height: _____ ft. _____ in.
8. Your weight: _____ lbs.
9. Your job title: _____
10. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____
11. The best time to phone you at this number: _____
12. 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)

13. Check the type of respirator you will use (you can check more than one category):
    A. _____ N, R, or P Disposable Respirator ("dust mask", filter-mask, non-cartridge type only).
    B. _____ Half or Full-Face Negative Pressure Air Purifying Respirator
    C. _____ Powered Air Purifying Respirator
    D. _____ Supplied Airline Respirator
    E. _____ Self-Contained Breathing Apparatus (SCBA) Respirator
14. Have you worn a respirator (circle one): Yes / No
    If "yes," what type(s): _____
    _____

Part A. Section 2. (Mandatory) Questions 1 through 17 below must be answered by every employee who has been selected to use any type of respirator (please 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 you think 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, go 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: Yes/No

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(s) (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
       If "yes," how long does this period last during the average shift:_____hrs._____mins.

    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
       If "yes," how long does this period last during the average shift:_____hrs._____mins.

    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
       If "yes," how long does this period last during the average shift:_____hrs._____mins.

    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
    If "yes," describe this protective clothing and/or equipment: _____

    _____

Employee Name:_____

College / Department:_____

Supervisor:_____

Campus Phone Number:_____

EMPLOYEE DO NOT WRITE BELOW THIS LINE

COWELL STUDENT HEALTH CENTER: PLEASE COMPLETE THE FOLLOWING INFORMATION, RETURN A COPY OF THIS PAGE TO EH&S TRAILER (attention Industrial Hygiene 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:

A. _____ N, R, or P Disposable Respirator ("dust mask", filter-mask, non-cartridge type only)

B. _____ Half or Full Face Negative Pressure Air Purifying Respirator

C. _____ Powered Air Purifying Respirator

D. _____ Supplied Airline Respirator

E. _____ Self Contained Breathing Apparatus (SCBA) Respirator

Signature:_____ Date:_____