|  |
| --- |
| **Please submit completed form to:** |
| **For Employees, Residents and Fellows:** | **For Students:** |
| Employee Health Services UCT 1620Occupational.Health@uth.tmc.eduFax #: 713-486-0983­ Attention: Sara Ransom or Sherry SnookPhone #: 713-500-3267 | Student Health Clinic6410 Fannin Street, Suite 130Ms.studenthealthclinic@uth.tmc.eduFax #: 713-500-0605Attention: Donna BoonePhone #: 713-500-5171 |

# **Medical Questionnaire For Respiratory Protection**

To The Employee/Student:

 **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.

**Medical Questionnaire for Respiratory Protection**

**Part A. Section I. (Mandatory)**

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

Employee ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male / Female

Height: \_\_\_\_\_ ft \_\_\_\_\_ inch. Weight: \_\_\_\_\_

Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title/Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code) ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The best time to phone you at this number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one) **YES NO**
2. Check the type of respirator you will use (you can check more than one category):

 a. \_\_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only) Example: N95 respirator)

 b. \_\_\_\_\_\_ Other . Circle type(s): Half or Full Facepiece Respirator, Powered air-purifying respirator (PAPR), Self-contained breathing apparatus (SCBA).

 3. Have you ever worn a respirator? (circle one): **YES NO**

If “Yes”, what type(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part A. Section II. (Mandatory)**

Questions 1 through 9 **must be answered by every employee/student who has been selected to use any type of respirator** (Please circle the “YES” or “NO” or check the appropriate box):

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month:

##  YES NO

1. Have you *ever had* any of the following conditions?

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Had in past** | **Have at Present** | **Never****had** |
| Seizures (fits) |[ ] [ ] [ ]
| Diabetes (sugar disease) |[ ] [ ] [ ]
| Allergic reactions that interfere with your breathing |[ ] [ ] [ ]
| Claustrophobia (fear of closed-in places) |[ ] [ ] [ ]
| Trouble smelling odors |[ ] [ ] [ ]

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Had in past** | **Have at Present** | **Never****had** |
| Asbestosis |[ ] [ ] [ ]
| Asthma |[ ] [ ] [ ]
| Chronic bronchitis |[ ] [ ] [ ]
| Emphysema. |[ ] [ ] [ ]
| Pneumonia |[ ] [ ] [ ]
| Tuberculosis |[ ] [ ] [ ]
| Silicosis |[ ] [ ] [ ]
| Pneumothorax (collapsed lung) |[ ] [ ] [ ]
| Lung cancer |[ ] [ ] [ ]
| Broken ribs |[ ] [ ] [ ]
| Any chest injuries or surgeries |[ ] [ ] [ ]
| Any other lung problems that you’ve been told aboutExplain: |[ ] [ ] [ ]

1. Do you *currently* have any of the following symptoms of pulmonary or lung illness?

|  |  |  |
| --- | --- | --- |
| **Condition** | **Yes** | **No** |
| Shortness of breath |[ ] [ ]
| Shortness of breath when walking fast on level ground or walking up a slight hill or incline |[ ] [ ]
| Shortness of breath when walking with other people at an ordinary pace on level ground |[ ] [ ]
| Had to stop for breath when walking at your own pace on level ground |[ ] [ ]
| Shortness of breath when walking or dressing yourself |[ ] [ ]
| Shortness of breath that interferes with your job |[ ] [ ]
| 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 |[ ] [ ]
| Wheezing that interferes with your job |[ ] [ ]
| Chest pain when you breathe deeply |[ ] [ ]
| Any other symptoms that you think may be related to lung problems? Explain: |[ ] [ ]

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Had in past** | **Have at Present** | **Never****had** |
| Heart Attack |[ ] [ ] [ ]
| Stroke |[ ] [ ] [ ]
| Angina |[ ] [ ] [ ]
| Heart Failure |[ ] [ ] [ ]
| Swelling in your legs or feet (not caused by walking) |[ ] [ ] [ ]
| Heart arrhythmia (heart beating irregularly) |[ ] [ ] [ ]
| High blood pressure |[ ] [ ] [ ]
| Any other heart problem that you’ve been told about?Explain: |[ ] [ ] [ ]

1. Have you *ever had* any of the following cardiovascular symptoms?

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Had in past** | **Have at Present** | **Never****had** |
| Frequent pain or tightness in your chest |[ ] [ ] [ ]
| Pain or tightness in your chest during physical activity |[ ] [ ] [ ]
| Pain or tightness in your chest that interferes with your job |[ ] [ ] [ ]
| In the past two years, have you noticed your heart skipping or missing a beat |[ ] [ ] [ ]
| Heartburn or indigestion that is not related to eating  |[ ] [ ] [ ]
| Any other symptoms that you think may be related to heart or circulation problems?Explain: |[ ] [ ] [ ]

1. Do you *currently* take medication for any of the following problems?

|  |  |  |
| --- | --- | --- |
| **Condition** | **Yes** | **No** |
| Breathing or lung problem |[ ] [ ]
| Heart trouble |[ ] [ ]
| Blood pressure |[ ] [ ]
| Seizures (fits) |[ ] [ ]

1. 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):

|  |  |  |
| --- | --- | --- |
| **Condition** | **Yes** | **No** |
| Eye irritation |[ ] [ ]
| Skin allergies or rashes |[ ] [ ]
| Anxiety |[ ] [ ]
| General weakness or fatigue |[ ] [ ]
| Any other problem that interferes with your use of a respirator?Explain: |[ ] [ ]

1. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: **YES NO**
2. Have you ever lost vision in either eye (temporarily or permanently) **YES NO**

If yes, was vision loss permanent? **YES NO**

1. Do you currently have any of the following vision problems?

|  |  |  |
| --- | --- | --- |
| **Condition** | **Yes** | **No** |
| Wear contact lenses |[ ] [ ]
| Wear glasses |[ ] [ ]
| Color blind |[ ] [ ]
| Any other eye or vision problemExplain: |[ ] [ ]

1. Have you ever had an injury to your ears, including a broken eardrum? **YES NO**
2. Do you *currently* have any of the following hearing problems?

|  |  |  |
| --- | --- | --- |
| **Condition** | **Yes** | **No** |
| Difficulty Hearing |[ ] [ ]
| Wear a hearing aid |[ ] [ ]
| Any other hearing or ear problems?Explain: |[ ] [ ]

1. Have you *ever had* a back injury? **YES NO**
2. Do you *currently* have any of the following musculoskeletal problems?

|  |  |  |
| --- | --- | --- |
| **Condition** | **Yes** | **No** |
| Weakness in any of your arms, hands, legs, or feet |[ ] [ ]
| Back pain |[ ] [ ]
| Difficulty fully moving your arms and legs |[ ] [ ]
| Pain or stiffness when you lean forward or backward at the waist |[ ] [ ]
| Difficulty fully moving your head up or down |[ ] [ ]
| Difficulty fully moving your head side to side |[ ] [ ]
| Difficulty bending at your knees |[ ] [ ]
| Difficulty squatting to the ground |[ ] [ ]
| Climbing a flight of stairs or a ladder carrying more than 25 lbs. |[ ] [ ]
| Any other muscle or skeletal problem that interferes with using a respirator?Explain: |[ ] [ ]