Respirator Medical Evaluation Questionnaire

CCR, TITLE 8, 5144

To the employee

This questionnaire is only to be distributed to and completed by individuals who are proficient in reading and writing English.

Your supervisor at UCI must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. Your supervisor is not permitted to look at or review your answers. To maintain your confidentiality, please send your responses directly to the licensed health care professional listed below.

Occupational Health Program Coordinator
Email: occhlth@uci.edu
Phone: (949) 824-8024
Fax: (949) 824-1325 (confidential fax machine)
Zot 2725

This evaluation is **mandatory** to help determine your ability to wear a respirator at UCI. Your answers will remain confidential. After a review of your responses, the licensed health care professional may in some cases recommend that you receive a physical exam to complete your evaluation. Once you have received medical clearance to wear a respirator, you and your supervisor will receive notification of your approval to be fitted for a respirator.

PART A. SECTION 1. (*please print***)**

1. Today's date ____/____/_____/

2. Name _____ _____ Employee No._____
   First Name *Last Name*

3. Your Age _____ Date of Birth _____/_____/_____

4. Sex ☐ Male ☐ Female

5. Your height _____ft._____in. 6. Your weight _____ lbs.

7. Your Job title _____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code) _____ Your e-mail _____

9. The best time to phone you at this number _____

10. Your Supervisor's Name _____

11. Your Supervisor's Phone No._____ Your Supervisor's e-mail_____

12. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ No ☐ Yes

13. 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

    b. Other type ☐, half- or full-facepiece ☐, powered-air purifying ☐, supplied-air ☐, self-contained breathing apparatus ☐

    c. I don't know ☐

14. Have you worn a respirator? ☐ No ☐ Yes If "yes," what type(s) _____

PART A. SECTION 2.

1.	Do you currently smoke tobacco, or have you smoked tobacco in the last month?	☐ No	☐ Yes
2.	Have you ever had any of the following conditions?	☐ No	☐ Yes
	a. Seizures (fits)	☐ No	☐ Yes
	b. Diabetes (sugar disease)	☐ No	☐ Yes
	c. Allergic reactions that interfere with your breathing	☐ No	☐ Yes
	d. Claustrophobia (fear of closed-in places)	☐ No	☐ Yes
	e. Trouble smelling odors	☐ No	☐ Yes
3.	Have you ever had any of the following pulmonary or lung problems?		
	a. Asbestosis	☐ No	☐ Yes
	b. Asthma	☐ No	☐ Yes
	c. Chronic bronchitis	☐ No	☐ Yes
	d. Emphysema	☐ No	☐ Yes
	e. Pneumonia	☐ No	☐ Yes
	f. Tuberculosis	☐ No	☐ Yes
	g. Silicosis	☐ No	☐ Yes
	h. Pneumothorax (collapsed lung)	☐ No	☐ Yes
	i. Lung cancer	☐ No	☐ Yes
	j. Broken ribs	☐ No	☐ Yes
	k. Any chest injuries or surgeries	☐ No	☐ Yes
	l. Any other lung problem that you've been told about	☐ No	☐ Yes
4.	Do you **currently** have any of the following symptoms of pulmonary or lung illness?		
	a. Shortness of breath	☐ No	☐ Yes
	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐ No	☐ Yes
	c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐ No	☐ Yes
	d. Have to stop for breath when walking at your own pace on level ground	☐ No	☐ Yes
	e. Shortness of breath when washing or dressing yourself	☐ No	☐ Yes
	f. Shortness of breath that interferes with your job	☐ No	☐ Yes
	g. Coughing that produces phlegm (thick sputum)	☐ No	☐ Yes
	h. Coughing that wakes you early in the morning	☐ No	☐ Yes
	i. Coughing that occurs mostly when you are lying down	☐ No	☐ Yes
	j. Coughing up blood in the last month	☐ No	☐ Yes
	k. Wheezing	☐ No	☐ Yes
	l. Wheezing that interferes with your job	☐ No	☐ Yes
	m. Chest pain when you breathe deeply	☐ No	☐ Yes
	n. Any other symptoms that you think may be related to lung problems	☐ No	☐ Yes
5.	Have you **ever had** any of the following cardiovascular or heart problems?		
	a. Heart attack	☐ No	☐ Yes
	b. Stroke	☐ No	☐ Yes
	c. Angina	☐ No	☐ Yes
	d. Heart failure	☐ No	☐ Yes
	e. Swelling in your legs or feet (not caused by walking)	☐ No	☐ Yes
	f. Heart arrhythmia (heart beating irregularly)	☐ No	☐ Yes
	g. High blood pressure	☐ No	☐ Yes
	h. Any other heart problem that you've been told about	☐ No	☐ Yes
6.	Have you **ever had** any of the following cardiovascular or heart symptoms?		
	a. Frequent pain or tightness in your chest	☐ No	☐ Yes
	b. Pain or tightness in your chest during physical activity	☐ No	☐ Yes
	c. Pain or tightness in your chest that interferes with your job	☐ No	☐ Yes
	d. In the past two years, have you noticed your heart skipping or missing a beat	☐ No	☐ Yes
	e. Heartburn or indigestion that is not related to eating	☐ No	☐ Yes
	f. Any other symptoms that you think may be related to heart or circulation problems	☐ No	☐ Yes

7. Do you **currently** take medication for any of the following problems?
   a. Breathing or lung problems ☐ No ☐ Yes
   b. Heart trouble ☐ No ☐ Yes
   c. Blood pressure ☐ No ☐ Yes
   d. Seizures (fits) ☐ No ☐ Yes

8. If you've used a respirator, have you **ever had** any of the following problems? *(If you've never used a respirator, check the following space and go to question 9)*
   a. Eye irritation ☐ No ☐ Yes
   b. Skin allergies or rashes ☐ No ☐ Yes
   c. Anxiety ☐ No ☐ Yes
   d. General weakness or fatigue ☐ No ☐ Yes
   e. Any other problem that interferes with your use of a respirator ☐ No ☐ Yes

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire ☐ No ☐ Yes

PART A. SECTION 3.

QUESTIONS 10 - 15 ARE MANDATORY FOR ALL EMPLOYEES WHO WEAR A FULL-FACEPIECE RESPIRATOR OR A SELF-CONTAINED BREATHING APPARATUS (SCBA). OTHERS MAY ANSWER THESE QUESTIONS VOLUNTARILY.

10. Have you **ever lost** vision in either eye (temporarily or permanently) ☐ No ☐ Yes

11. Do you **currently** have any of the following vision problems?
   a. Wear contact lenses ☐ No ☐ Yes
   b. Wear glasses ☐ No ☐ Yes
   c. Color blind ☐ No ☐ Yes
   d. Any other eye or vision problem ☐ No ☐ Yes

12. Have you **ever had** an injury to your ears, including a broken ear drum? ☐ No ☐ Yes

13. Do you **currently** have any of the following hearing problems?
   a. Difficulty hearing ☐ No ☐ Yes
   b. Wear a hearing aid ☐ No ☐ Yes
   c. Any other hearing or ear problem ☐ No ☐ Yes

14. Have you **ever had** a back injury? ☐ No ☐ Yes

15. Do you **currently** have any of the following musculoskeletal problems?
   a. Weakness in any of your arms, hands, legs, or feet ☐ No ☐ Yes
   b. Back pain ☐ No ☐ Yes
   c. Difficulty fully moving your arms and legs ☐ No ☐ Yes
   d. Pain or stiffness when you lean forward or backward at the waist ☐ No ☐ Yes
   e. Difficulty fully moving your head up or down ☐ No ☐ Yes
   f. Difficulty fully moving your head side to side ☐ No ☐ Yes
   g. Difficulty bending at your knees ☐ No ☐ Yes
   h. Difficulty squatting to the ground ☐ No ☐ Yes
   i. Climbing a flight of stairs or a ladder carrying more than 25 lbs. ☐ No ☐ Yes
   j. Any other muscle or skeletal problem that interferes with using a respirator ☐ No ☐ Yes

PART B SUPPLEMENTAL QUESTIONS

*Any of the following questions, and other questions not listed, **MAY** be added to the questionnaire at the discretion of the health care professional who will review the questionnaire*.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? ☐ No ☐ Yes

   If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions? ☐ No ☐ Yes

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals? ☐ No ☐ Yes
   If "yes," name the chemicals if you know them _____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below
   a. Asbestos ☐ No ☐ Yes
   b. Silica (e.g**.,** in sandblasting) ☐ No ☐ Yes
   c. Tungsten/cobalt (e.g., grinding or welding this material) ☐ No ☐ Yes
   d. Beryllium ☐ No ☐ Yes
   e. Aluminum ☐ No ☐ Yes
   f. Coal (for example, mining) ☐ No ☐ Yes
   g. Iron ☐ No ☐ Yes
   h. Tin ☐ No ☐ Yes
   i. Dusty environments ☐ No ☐ Yes
   j. Any other hazardous exposures ☐ No ☐ Yes
      If "yes," describe these exposures _____

4. List any second jobs or side businesses you have _____

5. List your previous occupations _____

6. List your current and previous hobbies _____

7. Have you been in the military services? ☐ No ☐ Yes
   If "yes," were you exposed to biological or chemical agents (either in training or combat)? ☐ No ☐ Yes

8. Have you ever worked on a HAZMAT team? ☐ No ☐ Yes

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? ☐ No ☐ Yes
   If "yes," name the medications if you know them _____

10. Will you be using any of the following items with your respirator(s)?
    a. HEPA Filters ☐ No ☐ Yes
    b. Canisters (for example, gas masks) ☐ No ☐ Yes
    c. Cartridges ☐ No ☐ Yes

11. How often are you expected to use the respirator(s) *(mark "yes" or "no" for all answers that apply to you)?*
    a. Escape only (no rescue) ☐ No ☐ Yes
    b. Emergency rescue only ☐ No ☐ Yes
    c. Less than 5 hours **per week** ☐ No ☐ Yes
    d. Less than 2 hours **per day** ☐ No ☐ Yes
    e. 2 to 4 hours per day ☐ No ☐ Yes
    f. Over 4 hours per day ☐ No ☐ Yes

12. During the period you are using the respirator(s), is your work effort
    a. **Light** (less than 200 kcal per hour) ☐ No ☐ Yes

    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) ☐ No ☐ Yes

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 I 00 lbs.) on a level surface.*

c. **Heavy** (above 350 kcal per hour) ☐ No ☐ Yes

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.).*

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? ☐ No ☐ Yes
If “yes," describe this protective clothing and/or equipment _____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F)? ☐ No ☐ Yes

15. Will you be working under humid conditions? ☐ No ☐ Yes

16. Describe the work you'll be doing while you're using your respirator(s)? ☐ No ☐ Yes

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) *(for example, confined spaces, life-threatening gases)*

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s)

Name of the first toxic substance _____

Estimated maximum exposure level per shift _____

Duration of exposure per shift _____

Name of the second toxic substance _____

Estimated maximum exposure level per shift _____

Duration of exposure per shift _____

Name of the third toxic substance _____

Estimated maximum exposure level per shift _____

Duration of exposure per shift _____

The name of any other toxic substances that you'll be exposed to while using your respirator _____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security)

_____