University of California, Davis

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OCCUPATIONAL HEALTH SERVICES
One Shields Avenue
Davis, CA 95616-8764
(530) 752-6051; Fax (530) 752-5277

Periodic Evaluation for Respirator Use (non-SCBA users)
Employee Medical Questionnaire (OSHA Mandated Evaluation Questionnaire)

Name:_____ Date of Birth:_____ Age: _____

Employee ID:_____ Today's Date: _____

Address: _____ Phone #_____

To the employee – Can you read (check 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 you employer must tell you how to deliver or send this questionnaire to the health care professional who will review it. For the University of California Davis Campus, the reviewing health care provider is located at Occupational Health Services (530-752-6051). Your supervisor will also need to complete a Request and Authorization form authorizing the review of this questionnaire and sent it to Occupational Health Services. The questionnaire should be faxed to Occupational Health Services (fax: 530-752-5277). Both the questionnaire and authorization form must be received and reviewed **prior** to scheduling a fitting appointment. Do not give the completed questionnaire to your supervisor.

Section 1
Every employee required to use any type of respirator must provide the following information (please print).

1. Sex (check one): ☐ Male ☐ Female 2. Height: _____ ft. _____ in. 3. Weight _____lbs

4. Job Title: _____ Dept: _____

5. Phone # that the reviewing health care professional can call you (include Area Code): _____

6. The best time to phone you at this number? _____

7. Has your supervisor told you how to contact the reviewing health care professional? ☐ Yes ☐ No

8. Check the type(s) of respirator you will use:
   a. N, R, or P disposable respirator (filter-mask, non-cartridge type only) ☐ Yes ☐ No
   b. Half or full face piece type ☐ Yes ☐ No
   c. Powered-air purifying, supplied-air ☐ Yes ☐ No
   d. Self-contained breathing apparatus ☐ Yes ☐ No

9. Have you worn a respirator? ☐ Yes ☐ No

If yes, what type(s)?

a. N, R, or P disposable respirator (filter-mask, non-cartridge type only)	☐ Yes	☐ No
b. Half- or full-face piece type	☐ Yes	☐ No
c. Powered-air purifying, supplied-air	☐ Yes	☐ No
d. Self-contained breathing apparatus	☐ Yes	☐ No

Section 2

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 have been told about	☐ Yes	☐ No

4. Do you currently have any of the following syptoms 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 your 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 of feet (not caused by walking)	☐ Yes	☐ No
f. Heart arrhythmia	☐ Yes	☐ No

g. High blood pressure ☐ Yes ☐ No
h. Any other heart problem that you have 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 have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check "no" for all and 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 about your answers to this questionnaire? ☐ Yes ☐ No