

**UNIVERSITY OF CALIFORNIA, SAN DIEGO
MEDICAL EVALUATION QUESTIONNAIRE
FOR RESPIRATOR-USE CERTIFICATION**

Name: _____ Date: _____
DOB: _____ Job Title: _____
Sex: M/F Age: _____ Height: _____ft_____in Weight: _____
Phone #: _____ Best Time to Call at this #: _____

This questionnaire will be reviewed by a health care professional at the UCSD Occupational/Environmental Medicine Department (619-471-9210).

Check the type of respirator you will use (you can check more than one category):

- a. _____ N, R, or P disposable filtering face piece (filter-mask, non-cartridge type)
- b. _____ Air purifying cartridge (i.e., half- or full-facepiece, powered-air-purifying)
- c. _____ Air supplied (i.e., air-line, self-contained breathing apparatus)

Have you worn a respirator: Yes/No If "yes," what type(s) _____

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 medical conditions? If YES, how long have you had the condition?** (Please give a brief explanation on the dotted lines below.)

- a. Seizures Yes / No
 - b. Diabetes..... Yes / No
 - c. Allergic reactions that interfere with your breathing Yes / No
 - d. Claustrophobia Yes / No
 - e. Troubling smelling odors Yes / No
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3. **Have you ever had any of the following pulmonary or lung problems? If YES, how long have you had the problem?** (Please give a brief explanation on the dotted lines below.)

- 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 injuries or surgeries to the chest..... Yes / No
- l. Any other lung conditions (that you have been told about)..... Yes / No

4. Do you currently have any of the following symptoms of pulmonary or lung illness? If YES, how long have you had the illness? (Please give a brief explanation on the dotted lines below.)

- a. Shortness of breath Wwhile at rest..... Yes / No
 - b. Shortness of breath while walking fast, walking up a slight incline or hill..... Yes / No
 - c. Shortness of breath while walking with other people at an ordinary pace
on level ground..... Yes / No
 - d. Shortness of breath while doing everyday-type activities Yes / No
 - e. Shortness of breath that interferes with your job Yes / No
 - f. Coughing that produces phlegm..... Yes / No
 - g. Coughing up blood in the last month..... Yes / No
 - h. Coughing that occurs mostly while you lie down..... Yes / No
 - i. Coughing that wakes you early in the morning Yes / No
 - j. Chest pains when you breathe deeply Yes / No
 - k. Any wheezing Yes / No
 - l. Wheezing that interferes with your job..... Yes / No
 - m. Do you ever have to stop for a breath while walking on level ground..... Yes / No
 - n. Do you have any other symptoms related to lung problems..... Yes / No
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5. Have you ever had any of the following cardiovascular or heart problems? If YES, how long have you had the problem? (Please give a brief explanation on the dotted lines below.)

- a. Heart attack Yes / No
 - b. Irregular heart beat (arrhythmia)..... Yes / No
 - c. Stroke Yes / No
 - d. Angina (chest pain)..... Yes / No
 - e. Heart Failure..... Yes / No
 - f. Swelling of the legs or feet..... Yes / No
 - g. High blood pressure Yes / No
 - h. Any other heart problems..... Yes / No
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6. Have you ever had any of the following cardiovascular or heart symptoms? If YES, how long have you had these symptoms? (Please give a brief explanation on the dotted lines below.)

- a. Frequent tightness or pain in the chest..... Yes / No
- b. Pain or tightness in the chest during physical activity Yes / No
- c. Pain or tightness in the chest that interferes with your job Yes / No

- d. Have you noticed your heart skipping or missing beats Yes / No
 - d. Heartburn or indigestion not related to eating Yes / No
 - e. Other symptoms that you think might be related to the heart..... Yes / No
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7. Do you currently take medication for any of the following problems? If YES, how long have you been taking these medications? (Please give a brief explanation on the dotted lines below.)

- a. Breathing or lung problems..... Yes / No
 - b. Heart trouble Yes / No
 - c. High blood pressure Yes / No
 - d. Seizures (fits) Yes / No
-

8. While wearing a respirator, have you ever had any of the following problems? (Skip these if you haven't worn a respirator before.) If YES, how long have you had these problems? (Please give a brief explanation on the dotted lines below.)

- a. Eye irritations Yes / No
 - b. Skin allergies or rashes Yes / No
 - c. Anxiety Yes / No
 - d. General weakness or fatigue (tiredness) Yes / No
 - e. Any other problems that interfere with use of your respirator..... Yes / No
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9. Do you know how to contact the UCSD Occupational/Environmental Medicine Department health care professional who will review this questionnaire? Yes / No

10. Would you like to talk to the health care professional who will review your answers on this questionnaire? Yes / No

I agree that I have answered the above questions to the best of my knowledge.

Employee's signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____

Comments:

Referred by UCSD Environment, Health & Safety Office
Industrial Hygiene, Mail Code 0958, 09/21/04

You only have to answer the following questions if you will be wearing a full face piece respirator (either air supplied or air purifying) ,or a self-contained breathing apparatus (SCBA). Otherwise, you may choose to skip the remaining questions.

15. Have you ever had (now or before) any of the following? If YES, how long have you had these problems? (Please give a brief explanation on the dotted lines below.)

- a. Loss of vision in either eye (temporarily or permanently)..... Yes / No
 - b. Wear contact lenses..... Yes / No
 - c. Wear glasses (spectacles)..... Yes / No
 - d. Color blindness Yes / No
 - e. Any other vision problems Yes / No
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16. Have you ever had (now or before) any of the following? If YES, how long have you had these problems? (Please give a brief explanation on the dotted lines below.)

- a. Injury to the ears, including a broken ear drum Yes / No
 - b. Difficulty hearing..... Yes / No
 - c. A hearing aid Yes / No
 - d. Any other hearing problem Yes / No
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17. Have you ever had (now or before) any of the following? If YES, how long have you had these problems? (Please give a brief explanation on the dotted lines below.)

- a. Back injury or back pain Yes / No
 - b. Weakness in the arms, hands, legs, or feet Yes / No
 - c. Difficulty moving arms and / or legs Yes / No
 - d. Pain or stiffness when you lean backward or forward at the waist..... Yes / No
 - e. Difficulty fully moving the head up or down, or side to side Yes / No
 - f. Difficulty bending at the knees or squatting to the ground Yes / No
 - g. Difficulty climbing stairs or ladders while carrying greater than 25 pounds Yes / No
 - h. Other muscle-skeletal problems that interferes with using a respirator Yes / No
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Employee initials: _____

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Industrial Hygiene, Mail Code 0958, 09/21/04