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

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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. **<u>Do you currently have any of the following symptoms of pulmonary or lung illness? If YES, how long have you had the illness?</u>** **(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. **<u>Have you ever had any of the following cardiovascular or heart problems? If YES, how long have you had the problem?</u>** **(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. **<u>Have you ever had any of the following cardiovascular or heart symptoms? If YES, how long have you had these symptoms?</u>** **(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

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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

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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