University of Arizona Campus Health Service
OSHA Respirator Medical Evaluation Questionnaire

Please fill out this form, so we can help determine if you have medical conditions that could affect your ability to wear a respirator. Some people will also need to be seen by a physician. If this is true for you, a nurse will call you to schedule an appointment. For questions, please call (520) 621-2292 to talk with a nurse. Please fill out this form to the best of your ability and deliver to the Immunization Department.

Today's Date: _____ Employee/Student ID#: _____

Name: _____
Last *First* *Middle*

DOB: Height: (ft) (in) Weight:

Job Title: Department: Supervisor:

Home/Cell Phone: ( ) Work Phone: UA Email:

1. Have you ever been fitted to a respirator? □ Yes □ No
   If Yes, what type? □ N95 □ Half face respirator □ Full face respirator □ PAPR □ Other: _____
2. Do you currently smoke tobacco or have you smoked tobacco in the last month? □ Yes □ No
3. Have you *ever had* any of the following conditions?
   a. Claustrophobia ..... □ Yes □ No
   b. Diabetes..... □ Yes □ No
   c. Seizures..... □ Yes □ No
   d. Trouble smelling odors.....□ Yes □ No
   e. Allergic reaction that interferes with breathing .....□ Yes □ No
4. Have you *ever had* any of the following pulmonary (lung) problems?
   a. Asbestosis ...□ Yes □ No
   b. Asthma.....□ Yes □ No
   c. Broken ribs..□ Yes □ No
   d. Emphysema □ Yes □ No
   e. Chest injury/surgery □ Yes □ No
   f. Chronic bronchitis....□ Yes □ No
   g. Collapsed lung.....□ Yes □ No
   h. Lung Cancer .....□ Yes □ No
   i. Pneumonia ..... □ Yes □ No
   j. Silicosis..... □ Yes □ No
   k. Tuberculosis..... □ Yes □ No
   l. Other: _____
5. Do you ***currently have*** any of the following pulmonary (lung) problems?
   a. Shortness of breath ..... □ Yes □ No
   b. Shortness of breath when walking fast on ground level or walking up a slight hill/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 you breathe deeply..... □ Yes □ No
   n. Other: _____
6. Have you *ever had* any of the following cardiovascular (heart) problems?
   a. Angina.....□ Yes □ No
   b. Arrhythmia (irregular heart beat) □ Yes □ No
   c. CHF (Heart Failure) .....□ Yes □ No
   d. Heart attack.....□ Yes □ No
   e. HTN (High blood pressure).....□ Yes □ No
   f. Stroke ..... □ Yes □ No
   g. Swelling in legs/feet (not from walking) .....□ Yes □ No
   h. Any other heart problem ..... □ Yes □ No

7. Have you *ever had* any of the following cardiovascular (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 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

8. Do you ***currently*** take medication for any of the following problems?
   a. Breathing or lung problems.....□ Yes □ No
   b. Blood pressure.....□ Yes □ No
   c. Heart problems .....□ Yes □ No
   d. Seizures .....□ Yes □ No

9. If you have worn a respirator, have you ever had any of the following problems? (skip if you have not worn a respirator)
   e. Anxiety.....□ Yes □ No
   f. Eye irritation .....□ Yes □ No
   g. General weakness or fatigue .....□ Yes □ No
   h. Skin allergies or rashes.....□ Yes □ No

10. Would you like to talk to the healthcare professional who will review this form? ..... □ Yes □ No

****Questions 11-16:** Answer **only** if you are selected to wear a full-faced tight fitting respirator or a Self-Contained Breathing Apparatus (SCBA). For employees selected to use other types of respirators, please skip to question #17.

11. Have you ever lost vision in either eye (temporarily or permanently)?.....□ Yes □ No

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

13. Have you ever had an injury to your ears, including a broken ear drum?

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

15. Have you ever had a back injury? □ Yes □ No

16. Do you currently have any of the following musculoskeletal problems?
   a. Weakness in your arms, legs, hands, or feet.....□ Yes □ No
   b. Back pain .....□ Yes □ No
   c. Difficulty fully moving your arms or legs.....□ Yes □ No
   d. Difficulty fully moving your head up and down .....□ Yes □ No
   e. Difficulty moving your head side to side .....□ Yes □ No
   f. Pain or stiffness leaning forward or backward at the waist.....□ Yes □ No
   g. Difficulty bending at your knees .....□ Yes □ No
   h. Difficulty squatting to the ground .....□ Yes □ No
   i. Difficulty climbing a flight of stairs or a ladder carrying 25lbs .....□ Yes □ No
   j. Other muscle or skeletal problems that may interfere with using a respirator.....□ Yes □ No

17. Please expand on any of the items above that you answered yes: _____

_____

I verify that the above information is true and complete to the best of my knowledge. I understand that further medical evaluation may be needed to determine my suitability for respirator use. I understand that this examination is designed to satisfy regulatory requirements and should not be considered to be a routine medical examination.

Print Name	*Signature*	*Date*