UTSA STUDENT/VOLUNTEER MEDICAL SURVEILLANCE INITIATIVE
Respirator Medical Evaluation Questionnaire

Last Name ___________________________ First Name ___________________________ Middle Name ___________________________ Date of Birth ____________

Sex □ Male □ Female Date you began this job ___________________________ Department ___________________________

Supervisor/PI ___________________________ Job Title ___________________________ Work phone ____________ Cell Phone ____________

Campus Bldg/Office Location ___________________________ Room # ___________________________ E-Mail ___________________________

(i.e BSB/ FSA)

Your height: _____ ft _____ in. Your weight: _________ lbs.

Type of respirator you will use (you can check more than one category)

Filter-mask, non-cartridge type only

□ N95/100  □ R95/100  □ P95/100

Other

□ Air-purifying (powered) (PAPR)  □ ½ Face with Cartridge  □ Supplied Air Respirator (SCBA)

□ Full Face with Cartridge

Make ___________________________ Model ___________________________ Cartridge ___________________________

Do you have prior/current experience wearing a respirator? □ No □ Yes - What type(s)? ___________________________

Extend of usage: □ Daily, # of hours _____ □ Occasionally (< twice a week) □ Rarely (Emergency uses only)

Physical Effort while wearing respirator

□ Light □ Moderate □ Heavy

Exposure to Hazardous Material (Check all that apply)

□ Arsenic  □ Coke Oven  □ Cadmium

□ Methylene Chloride  □ Textiles  □ Benzene

□ Cotton Seed/ Dust  □ Formaldehyde  □ Lead □ Chromium

While using a respirator have you ever had any of these problems (if you haven't used a respirator, proceed to next question)

Eye irritation □ No □ Yes

Skin allergies or rashes □ No □ Yes

Anxiety □ No □ Yes

General weakness or fatigue □ No □ Yes

Do you currently smoke tobacco or have you smoked tobacco in the last month? □ No □ Yes

Have you ever had any of the following conditions?

Seizures (fits) □ No □ Yes

Diabetes (sugar disease) □ No □ Yes

Allergic reactions that interfere with your breathing □ No □ Yes

Claustrophobia (fear of closed-in places) □ No □ Yes

Trouble smelling odors □ No □ Yes

Have you ever had any of the following pulmonary or lung problems?

Asbestosis □ No □ Yes  Silicosis □ No □ Yes

Asthma □ No □ Yes  Pneumothorax

Chronic bronchitis □ No □ Yes  (collapsed lung) □ No □ Yes

Emphysema □ No □ Yes  Lung cancer □ No □ Yes

Pneumonia □ No □ Yes  Broken ribs □ No □ Yes

Tuberculosis □ No □ Yes  Chest injuries/surgeries □ No □ Yes

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Do you currently have any of these symptoms of pulmonary / lung illness?

- Shortness of breath when:
  - Walking fast on level ground or up a slight hill or incline
  - Walking with people at ordinary pace on level ground
  - Have to stop for breath when walking at own pace on level ground
  - Shortness of breath when washing/dressing
  - Shortness of breath that interferes with your job
  - Coughing the produces phlegm
  - Coughing that wakes you early in the morning
  - Coughing that occurs mostly when you are lying down
  - Coughing up blood in the last month
  - Wheezing
  - Wheezing that interferes with your job
  - Chest pain when you breathe deeply

Have you ever had any of the following cardiovascular / heart problems?

- Heart Attack
- Stroke
- Angina
- Heart Failure
- Swelling in feet or legs not from walking
- Heart Arrhythmia (irregular heartbeat)
- High blood pressure

Have you ever had the following cardiovascular / heart symptoms?

- Frequent pain or tightness in chest
- Pain/tightness in chest during physical activity
- Pain/tightness in chest that interferes with work
- Heart skipping/missing a beat (last 2 years)
- Heartburn/indigestion not related to eating

Do you currently take medication for any of these problems?

- Breathing or lung problems
- Heart trouble
- Blood pressure
- Seizures

Employees who use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA) must answer the following questions:

Have you ever lost vision in either eye (temporarily or permanently)?

- Wear contact lenses
- Wear glasses
- Color blind

Have you had an injury to your ears (including a broken ear drum)?

- Difficulty hearing
- Wear a hearing aid

Have you ever had a back injury?

- Weakness in any arms, hands, legs or feet
- Back pain
- Difficulty moving your arms and legs
- Pain or stiffness when you lean forward or backward at the waist
- Difficulty moving your head up or down
- Difficulty moving your head side to side
- Difficulty bending at your knees
- Difficulty squatting to the ground
- Climbing a flight of stairs or a ladder carrying more than 25 lbs

Have you had exposure to hazardous solvents or hazardous airborne chemicals (e.g., gases, fumes, or dust), either at home or office.

- No
- Yes

List: ________________________________________________________________
Have you ever worked with any of these materials or under these conditions:

- Asbestos
  - No
  - Yes

- Coal
  - No
  - Yes

- Silica (e.g., in sandblasting)
  - No
  - Yes

- Iron
  - No
  - Yes

- Tungsten/cobalt (e.g., grinding or welding this material)
  - No
  - Yes

- Beryllium
  - No
  - Yes

- Aluminum
  - No
  - Yes

- Dusty environments
  - No
  - Yes

If yes, describe these exposures: ________________________________________________________________

List any second jobs or side businesses you have

List your previous occupations

List your current and previous hobbies

Have you ever been in the military service

- No
- Yes

If yes, were you exposed to biological or chemical agents (either in training or combat)

- No
- Yes

Have you ever worked on a HAZMAT team

- No
- Yes

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

___________________________________________________________________________________________

Physician Written Statement for Respirator Usage

Last Name (employee)                      First Name                   Middle Name               Date of Birth

Based on my findings I have determined that this individual

- No Restrictions on respirator use
- Employee must schedule a medical examination prior to respirator approval and usage.
- Some specific use restrictions
- Special prescription eyewear needed to accommodate respirator
- Respirator use is NOT PERMITTED
- Fit Test Performed Satisfactorily
- Used for emergency response or escape only
- Fit Test Required

Results

- The above individual HAS been examined for respirator fitness. Employees have been instructed to report any difficulties in using respirators or any change of physical status to their supervisor or physician.
- The above individual HAS NOT been examined by me for respirator fitness.
- I have informed the above individual of the results of this evaluation and of any medical conditions resulting from exposure that may require further explanation or treatment.

___________________________________________________________________________________________

Physician's Signature                  Physician's Name (Printed)  

Date  ___________________________________________                REVISED  6/28/2013

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