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
- ☐ Full Face with Cartridge
- ☐ Supplied Air Respirator (SCBA)

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
- ☐ Methylene Chloride
- ☐ Cotton Seed/ Dust
- ☐ Coke Oven
- ☐ Textiles
- ☐ Formaldehyde
- ☐ Cadmium
- ☐ Benzene
- ☐ 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	☐ No	☐ Yes
Walking with people at ordinary pace on level ground	☐ No	☐ Yes
Have to stop for breath when walking at own pace on level ground	☐ No	☐ Yes
Shortness of breath when washing/dressing	☐ No	☐ Yes
Shortness of breath that interferes with your job	☐ No	☐ Yes
Coughing the produces phlegm	☐ No	☐ Yes
Coughing that wakes you early in the morning	☐ No	☐ Yes
Coughing that occurs mostly when you are lying down	☐ No	☐ Yes
Coughing up blood in the last month	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes
Wheezing that interferes with your job	☐ No	☐ Yes
Chest pain when you breathe deeply	☐ No	☐ Yes

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

Heart Attack	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Angina	☐ No	☐ Yes
Heart Failure	☐ No	☐ Yes
Swelling in feet or legs not from walking	☐ No	☐ Yes
Heart Arrhythmia (irregular heartbeat)	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes

Have you ever had the following cardiovascular / heart **symptoms**

Frequent pain or tightness in chest	☐ No	☐ Yes
Pain/tightness in chest during physical activity	☐ No	☐ Yes
Pain/tightness in chest that interferes with work	☐ No	☐ Yes
Heart skipping/missing a beat (last 2 years)	☐ No	☐ Yes
Heartburn/indigestion not related to eating	☐ No	☐ Yes

Do you currently take medication for any of these problems

Breathing or lung problems	☐ No	☐ Yes
Heart trouble	☐ No	☐ Yes
Blood pressure	☐ No	☐ Yes
Seizures	☐ No	☐ Yes

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) ☐ No ☐ Yes

Do you currently have any of the following vision problems

Wear contact lenses ☐ No ☐ Yes Wear glasses ☐ No ☐ Yes Color blind ☐ No ☐ Yes

Have you had an injury to your ears (including a broken ear drum) ☐ No ☐ Yes

Do you currently have any of the following hearing problems

Difficulty hearing ☐ No ☐ Yes Wear a hearing aid ☐ No ☐ Yes

Have you ever had a back injury ☐ No ☐ Yes

Do you currently have any of the following musculoskeletal problems

Weakness in any arms, hands, legs or feet	☐ No	☐ Yes
Back pain	☐ No	☐ Yes
Difficulty fully moving your arms and legs	☐ No	☐ Yes
Pain or stiffness when you lean forward or backward at the waist	☐ No	☐ Yes
Difficulty fully moving you head up or down	☐ No	☐ Yes
Difficulty fully moving your head side to side	☐ No	☐ Yes
Difficulty bending at your knees	☐ No	☐ Yes
Difficulty squatting to the ground	☐ No	☐ Yes
Climbing a flight of stairs or a ladder carrying more than 25 lbs	☐ No	☐ Yes

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: _____

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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/colbalt (e.g., grinding or welding this material)	☐ No	☐ Yes	Tin	☐ No	☐ Yes
Beryllium	☐ No	☐ Yes	Dusty environments	☐ No	☐ Yes
Aluminum	☐ 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 _____ ☐ Used for emergency response or escape only
☐ Special prescription eyewear needed to accommodate respirator
☐ Respirator use is NOT PERMITTED

☐ Fit Test Performed Satisfactorily ☐ Fit Test Performed Satisfactorily ☐ 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 _____

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