ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL & TRAUMA CENTER

OCCUPATIONAL HEALTH SERVICE

RESPIRATOR MEDICAL EVALUATION

As per Appendix C 5144; California Code of Regulations Title 8 version 4/99

This questionnaire will be used in determining whether or not you have a medical condition that may affect your ability to wear a respirator. Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

PART A. SECTION 1 (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator

Please print

Name: *(Last, First)* _____   **Date:** _____

Age (to nearest year): _____   **Sex:**   Male   Female   **Height:** _____   **Weight:** _____ lbs.

Department: _____   **Job Title:** _____

Phone Number: _____   **Best Time to call:** _____

Do you know how to contact the OHS clinicians who will review this questionnaire:....................... YES   NO

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

a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only)   b. _____Other type (half-or full-facepiece, powered air-purifying, supplied air, self-contained breathing apparatus

Have you worn a respirator: .... YES   NO

If "yes" what type(s): _____

PART A. SECTION 2 (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator

Please check appropriate box:	YES	NO
1. Do you *currently* smoke tobacco, or have you smoked in the last month?		
2. Have you *ever had* any of the following conditions?		
a. Seizures (fits)		
b. Diabetes (sugar disease)		
c. Allergic reactions that interfere with your breathing		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling odors		
3. Have you *ever had* any of the following pulmonary or lung problems?		
a. Asbestosis		
b. Asthma		
c. Chronic bronchitis		
d. Emphysema		
e. Pneumonia		
f. Tuberculosis		
g. Silicosis		
h. Pneumothorax (collapsed lung)		
i. Lung cancer		
j. Broken ribs		
k. Any chest injuries or surgeries		
l. Any other lung problem that you've been told about: _____		

Please check appropriate box:	YES	NO
4. Do you *currently have* any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath		
b. Shortness of breath when walking fast on level ground or walking up a slight hill/incline		
c. Shortness of breath when walking with other people at an ordinary pace on level ground		
d. Have to stop for breath when walking at your own pace on level ground		
e. Shortness of breath when washing or dressing yourself		
f. Shortness of breath that interferes with your job		
g. Coughing that produces phlegm (thick sputum)		
h. Coughing that wakes you early in the morning		
i. Coughing that occurs mostly when you are lying down		
j. Coughing up blood in the last month		
k. Wheezing		
l. Wheezing that interferes with your job		
m. Chest pain when you breathe deeply		
n. Any other symptoms that you think may be related to lung problems: _____		
5. Have you *ever had* any of the following cardiovascular or heart problems?		
a. Heart attack		
b. Stroke		
c. Angina		
d. Heart failure		
e. Swelling in your legs or feet (not caused by walking)		
f. Heart arrhythmia (heart beating irregularly)		
g. High blood pressure		
h. Any other heart problem that you've been told about: _____		
6. Have you *ever had* any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest		
b. Pain or tightness in your chest during physical activity		
c. Pain or tightness in your chest that interferes with your job		
d. In the past two years, have you noticed your heart skipping or missing a beat		
e. Heartburn or indigestion that is not related to eating		
f. Any other symptoms that you think may be related to heart or circulation problems: _____		
7. Do you *currently* take medications for any of the following problems?		
a. Breathing or lung problems		
b. Heart trouble		
c. Blood pressure		
d. Seizures (fits)		
8. If you've used a respirator, have you ever had any of the following problems? **(If you've never used a respirator, check the following space... ....and go to question 9)**		
a. Eye irritation		
b. Skin allergies or rashes		
c. Anxiety		
d. General weakness or fatigue		
e. Any other problem that interferes with your use of a respirator: _____		
9. Would you like to talk to the health care professional who will review this questionnaire about your answers:		

Questions 10 to 15 below must be answered by every employee who has been selected to use either a **full-facepiece respirator or a self-contained breathing apparatus (SCBA).** For employees who have been selected to use other types of respirators, answering these questions is **VOLUNTARY.**

Please check appropriate box:	YES	NO
10. Have you *ever* lost vision in either eye (temporarily or permanently)?		
11. Do you *currently* have any of the following vision problems?		
a. Wear contact lenses		
b. Wear glasses		
c. Color blind		
d. Any other eye or vision problems: _____		
12. Have you ever had an injury to your ears, including a broken ear drum?		
13. Do you *currently* have any of the following hearing problems?		
a. Difficulty hearing		
b. Wearing a hearing aid		
c. Any other hearing or ear problem: _____		
14. Have you *ever* had a back injury?		
15. Do you *currently* have any of the following musculoskeletal problems?		
a. Weakness in any of your arms, hands, legs, or feet		
b. Back pain		
c. Difficulty fully moving your arms and legs		
d. Pain or stiffness when you lean forward or backward at the waist		
e. Difficulty fully moving your head up or down		
f. Difficulty fully moving your head side to side		
g. Difficulty bending at your knees		
h. Difficulty squatting to the ground		
i. Climbing a flight of stairs or ladder carrying more than 25 pounds		
j. Any other muscle or skeletal problem that interferes with using a respirator: _____		