

TO THE EMPLOYEE:

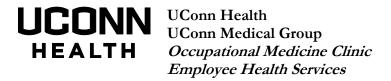
UConn Health
UConn Medical Group
Occupational Medicine Clinic
Employee Health Services

Respirator Medical Evaluation Questionnaire	Name
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Please complete the Sections of this questionnaire that apply to you. If you have medical questions call Employee Health Service at 679-2893.

Cai	n you read (check one): Yes No Respirator Category (check one): Required Voluntary								
is c	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. Return this completed questionnaire to FitTesting@uchc.edu.								
Par sel	Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator.								
1.	Today's date:								
2.	Your name:								
3.	Your date of birth:								
4.	Sex (select one): Male Female Other								
5.	Your height: ft in.								
6.	Your weight: lbs.								
7.	Your job title: Department/Work Area:								
8.	. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):								
9.	The best time to phone you at this number:								
10.	Your questionnaire is reviewed by the RN at the fit testing site or by the Occupational Medicine provider.								
	Acknowledge Yes								
11.	<ol> <li>Check the type of respirator you will use (you can check more than one category):         <ul> <li>a. N95, R, or P disposable respirator (filter-mask, non- cartridge type only).</li> <li>b. Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).</li> </ul> </li> </ol>								
12.	Have you worn a respirator (check one): Yes No								
	If "yes," what type(s):								

\*HCH1848\*



## **Respirator Medical Evaluation Questionnaire**

Name				

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

- 1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month: Yes No
- 2. Have you **ever had** any of the following conditions?
  - a. Seizures (fits): Yes No
  - b. Diabetes (sugar disease): Yes No
  - c. Allergic reactions that interfere with your breathing: Yes No
  - d. Claustrophobia (fear of closed-in places): Yes No
  - e. Trouble smelling odors: Yes No
- 3. Have you ever had any of the following pulmonary or lung problems?
  - 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 chest injuries or surgeries: Yes No
  - I. Any other lung problem that you've been told about: Yes No
- 4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
  - a. Shortness of breath: Yes No
  - b. Shortness of breath when walking fast on level ground or walking up a slight hill or 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
  - I. Wheezing that interferes with your job: Yes No
  - m. Chest pain when you breathe deeply: Yes No
  - n. Any other symptoms that you think may be related to lung problems: Yes No



## Occupational Medicine Clinic Employee Health Services

R	espirator Medical Evaluation Questionnaire	Name					
5.	Have you <b>ever had</b> any of the following cardiovascular or h	eart problems?					
	<ul> <li>a. Heart attack: Yes No</li> <li>b. Stroke: Yes No</li> <li>c. Angina Yes No</li> <li>d. Heart failure: Yes No</li> <li>e. Swelling in your legs or feet (not caused by walking):</li> <li>f. Heart arrhythmia (heart beating irregularly): Yes</li> <li>g. High blood pressure: Yes No</li> <li>h. Any other heart problem that you've been told about:</li> </ul>	Yes No No Yes No					
6.	Have you ever had any of the following cardiovascular or heart symptoms?						
	<ul> <li>a. Frequent pain or tightness in your chest: Yes N</li> <li>b. Pain or tightness in your chest during physical activity:</li> <li>c. Pain or tightness in your chest that interferes with your</li> <li>d. In the past two years, have you noticed your heart skipp</li> <li>e. Heartburn or indigestion that is not related to eating:</li> <li>f. Any other symptoms that you think may be related to he</li> </ul>	Yes No job: Yes No ping or missing a beat: Yes No	Yes No : Yes No				
7.	Do you currently take medication for any of the following problems?						
	<ul> <li>a. Breathing or lung problems: Yes No</li> <li>b. Heart trouble: Yes No</li> <li>c. Blood pressure: Yes No</li> <li>d. Seizures (fits): Yes No</li> </ul>						
8.	If you've used a respirator, have you <b>ever had</b> any of the following problems? (If you've never used a respirator, check the following space and go to question 9)						
	<ul> <li>a. Eye irritation: Yes No</li> <li>b. Skin allergies or rashes: Yes No</li> <li>c. Anxiety: Yes No</li> <li>d. General weakness or fatigue: Yes No</li> <li>e. Any other problem that interferes with your use of a res</li> </ul>	pirator: Yes No					
9.	Would you like to talk to the health care professional who w this questionnaire: Yes No	ill review this questionnaire	e about your answers to				
En	nployee Signature:	Date:	Time:				
Re	viewed by Signature:	Date:	Time:				