

## 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 complete the form to the best of your ability and upload it to your patient portal.

| Today's Da   | ate:   |   | Stud  | ent ID#:   |                |
|--|--|---|---|--|----------------|
| Name:  |  |   |   |  |                |
|  | Last   |   | First   | Middle   |                |
| DOB:   |  | College:  |   | UA Email:  |                |
| Home/Ce  | ell Phone: ( )   | Work Phone: ( )   |   |  |                |
|  | rou ever been fitted to a res<br>, what type? □ N95 □ Ha   | pirator? □ Yes<br>If face respirator  | □ No<br>□ Full face respirator  | □ PAPR □ Other:  |                |
| 2. Do you  | u currently smoke tobacco o  | r have you smoked t   | obacco in the last mon  | nth? □ Yes □ No  |                |
| 3. Have y<br>a.<br>b.<br>c.                                    |  |   |   |  |                |
| 4. Have y<br>a.<br>b.<br>c.<br>d.                              | rou ever had any of the follo Asbestosis Yes No Asthma Yes No Broken ribs Yes No Emphysema Yes No  | e. Chest injury/s<br>f. Chronic brond<br>g. Collapsed lun   | g) problems? curgery   Yes   No   chitis   Yes   No   g   Yes   No                                  | i. Pneumonia   | s 🗆 No         |
| a.<br>b.<br>c.<br>d.<br>e.<br>f.<br>g.<br>h.<br>i.<br>j.<br>k. | Shortness of breath when Shortness of breath when Have to stop for breath when Shortness of breath that is Coughing that produces p Coughing that wakes you Coughing that occurs mos Coughing up blood in the Wheezing | walking fast on grouwalking with other phen walking at your ownshing or dressing nterferes with your jublegm (thick sputumearly in the morning tly when you are lyinast month | and level or walking up<br>beople at an ordinary p<br>bwn pace on level grou<br>yourself<br>bb<br>) | a slight hill/incline   Yes bace on level ground   Yes und   Yes   Yes | No             |
| 6. Have y a. b. c.   | rou ever had any of the follo Angina Arrhythmia (irregular heart I CHF (Heart Failure)   | eat)   Yes   No   No   No   No   No   No   No   N   | e. HTN (High blood f. Stroke  | pressure) Yes Yes s/feet (not from walking) Yes  | □ No □ No □ 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   |        |  |  |  |
|   | 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 $\square$ Yes $\square$ No  |        |  |  |  |
| 0 | Do you suggestive take modification for any of the following much large?   |        |  |  |  |
| 8 | Do you <i>currently</i> take medication for any of the following problems?  a. Breathing or lung problems□ Yes □ No │ c. Heart problems□ Yes □ No  |        |  |  |  |
|   | a. Breathing or lung problems  |        |  |  |  |
|   | b. Blood pressure less la No la Seizures la res la 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 │ g. General weakness or fatigue ☐ Yes ☐ No  |        |  |  |  |
|   | f. Eye irritation ☐ Yes ☐ No  h. Skin allergies or rashes ☐ Yes ☐ No   |        |  |  |  |
| 1 | Would you like to talk to the healthcare professional who will review this form? 🗆 Yes 🗆 No  |        |  |  |  |
| Γ |  | $\neg$ |  |  |  |
|   | *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 □ c. Color blind□ Yes □ No   |        |  |  |  |
|   | b. Wear contact lenses□ 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 │ c. Any other hearing or ear problem ☐ Yes ☐ No  | )      |  |  |  |
|   | b. Wear a hearing aid□ 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 \( \sigma \) Yes \( \sigma \) No  |        |  |  |  |
|   | b. Back pain   |        |  |  |  |
|   | c. Difficulty fully moving your arms or legs No  |        |  |  |  |
|   | d. Difficulty fully moving your head up and down Pes Difficulty fully moving your head up and down   |        |  |  |  |
|   | e. Difficulty moving your head side to side  |        |  |  |  |
|   | f. Pain or stiffness leaning forward or backward at the waist Yes  |        |  |  |  |
|   | g. Difficulty bending at your knees 9 Yes 10 No  |        |  |  |  |
|   | h. Difficulty squatting to the ground  |        |  |  |  |
|   | i. Difficulty climbing a flight of stairs or a ladder carrying 25lbs   |        |  |  |  |
|   |  |        |  |  |  |
| L | j. Other muscle or skeletal problems that may interfere with using a respirator□ Yes □ No  |        |  |  |  |
| 1 | Please expand on any of the items above that you answered yes:   |        |  |  |  |
|   |  | _      |  |  |  |
| - |  | —      |  |  |  |
|   | erify that the above information is true and complete to the best of my knowledge. I understand that further medi  |        |  |  |  |
|   | aluation may be needed to determine my suitability for respirator use. I understand that this examination is design  | ıed    |  |  |  |
| ť | satisfy regulatory requirements and should not be considered to be a routine medical examination.  |        |  |  |  |
|   |  |        |  |  |  |
|   | Print Name Signature Date  |        |  |  |  |