UF Environmental Health and Safety
UNIVERSITY of FLORIDA

ANNUAL MEDICAL HISTORY QUESTIONNAIRE FOR RESPIRATOR USE

Occupational Medicine Program

Name:	**UFID #:**	**Date of Birth:**
Height:	**Weight:**	**Age:**

Position (Title):	**LP#:**
Supervisor:	**Department:**
Address:	**Work Telephone Number:**

Describe any apparent difficulties noted with respirator use, if any:

Have you had or do you now have any of the following:	**Yes**	**Within the Last Year?**	**No**
1. Lung disease			
2. Persistent cough			
3. Shortness of breath			
4. History of fainting or seizures			
5. Heart Trouble			
6. Frequent pain / tightness in chest			
7. Heartburn/indigestion not related to eating			
8. High blood pressure			
9. Diabetes			
10. Fear of tight or enclosed places			
11. Sensation of smothering			
12. Heat exhaustion or heat stroke			
13. Ruptured ear drum			
14. Defective vision			
15. Defective hearing			
16. Wear contact lenses or glasses			
17. Other conditions that might interferewith respirator use or result in limited work ability			
18. Are you taking any medications (prescription or over-the-counter) If Yes, LIST:			
19. Do you currently smoke? If Yes, how many do you smoke per day?			
20. Have you had a significant medical or surgical problem since your last respirator evaluation?			

Please Explain Yes Answers:

Employee's Signature:	Date:

Physician Use Only

❑ **No Restriction on Respirator Use** ❑ **Further Evaluation Needed**

Physician's Review Signature:	**Date:**