UF | Occupational Medicine Program
UNIVERSITY of FLORIDA

Respiratory Medical Evaluation Questionnaire

Applicant Information - *Please print legibly if applicable.*

Today's Date: | Date of Birth: | Height: (ft) (in)

Name: (Last, First): | UFID: | Weight: (lbs)

Department: | Phone: | Sex: ○ M ○ F

Has the Payment Authorization Form been submitted? ○ Yes ○ No

Has your employer told you how to contact the health care professional who will review this? ○ Yes ○ No

Can you read English? ○ Yes ○ No

Do you exercise? ○ Yes ○ No
If "yes," describe activity and frequency:

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

☐ Disposable, filter mask, non-catridge type only:
Filtering Facepiece,N95, N99, N100, R or P

☐ Other: Half - or full-facepiece, powered air-purifying, supplied-air, self-contained breathing apparatus (SCBA)

Have you worn a respirator in the past?

○ No *Please select "Initial Medical Evaluation" at right & then skip to Medical Questionnaire Section*

○ Yes If yes, what type(s):

Select Exam Type:

Use:
○ Respiratory Protection Only
○ Respiratory Protection and Pesticide Use

Status:
○ Initial Medical Evaluation
○ Annual Review

Physical exertion while wearing respirator: ☐ Mild ☐ Moderate ☐ Strenous

Maxium amount of time you wear a respirator in a single day: ☐ hours per day

Have you had the following problems while using a respirator?	Yes	No		Yes	No
No Eye irritation	○	○	General weakness or fatigue	○	○
Skin allergies or rashes	○	○	Other problem that interferes with respirator use If yes, please explain:	○	○
Anxiety	○	○			

For Annual Review Only: Answer all questions. If you are unsure about conditions or symptoms, click name for details.

Have you ever had any of the following conditions and/or have you experienced any changes in the following conditions within the last 12 months.

	Yes	12 Mo.	No		Yes	12 Mo.	No
1. Tobacco Usage	☐	☐	☐	7. Prescribed medications for respiratory or circulatory issues	☐	☐	☐
2. Seizures	☐	☐	☐	8. Symptoms of cardiovascular or heart problems (*chest pain*)	☐	☐	☐
3. Diabetes	☐	☐	☐	9. Cardiovascular or heart problems	☐	☐	☐
4. Allergic reactions in regards to breathing	☐	☐	☐	10. Pulmonary or lung problems	☐	☐	☐
5. Claustrophobia *(fear of closed-in places)*	☐	☐	☐	11. Symptoms of pulmonary or lung illness (*coughing, shortness of breath, wheezing*	☐	☐	☐
6. Trouble smelling odors Heat exhaustion/heat stroke	☐	☐	☐	12. Ruptured ear drum	☐	☐	☐

If answered "yes" to **any** question above, please explain in the corresponding medical questionnaire portion below. If answered "no" **to all** click here to sign and submit.

Medical Questionnaire

Tobacco Usage:

Do you currently smoke tobacco, or have you smoked tobacco in the last month? ○ Yes ○ No

If "yes", how many packs per day? ○ 1/2 or less ○ 1 ○ 2 ○ 2 or more

How many years have you smoked? ○ 1-9 ○ 10-19 ○ 20-29 ○ 30+

Conditions: Have you ever had any of the following:

	Yes	No		Yes	No	If yes to any, please explain:
Seizures (fits)/Fainting	○	○	Claustrophobia (fear of closed-in places)	○	○	
Diabetes (sugar disease)	○	○	Trouble smelling odors	○	○	
Allergic reactions that interfere with your breathing	○	○	Heat exhaustion or heat stroke	○	○	
Trouble concentrating or remembering	○	○	Ruptured ear drum	○	○	

Medications:

Do you currently take medications for any of the following:	Yes	No		Yes	No
Breathing or lung problems	○	○	Blood Pressure	○	○
Heart conditions	○	○	Seizure (fits)	○	○

Cardiovascular or heart symptoms:

Have you **ever** had any of the following symptoms:	Yes	No		Yes	No
Frequent pain or tightness in your chest	○	○	Skipping/missing heartbeat (in last 2 years)	○	○
Pain or tightness in your chest during physical activity	○	○	Heartburn-like symptoms not related to eating	○	○
Pain or tightness in your chest that interferes with your job	○	○	Any other heart/circulatory symptoms	○	○

continued on next page

Medical Questionnaire cont'd Last Name: UFID:

Cardiovascular or heart problems

Have you **ever** had any of the following problems:	Yes	No		Yes	No
Heart attack	○	○	Heart arrhythmia (heart beating irregularly)	○	○
Stroke	○	○	High blood pressure	○	○
Heart Failure	○	○	Any other heart problem that you've been told about	○	○
Swelling in your legs not caused by walking	○	○	If yes, please explain:		

Pulmonary or lung problems:

Have you **ever** had any of the following conditions:	Yes	No		Yes	No
Asbestosis	○	○	Silicosis	○	○
Asthma	○	○	Pneumothorax (collapsed lung)	○	○
Chronic bronchitis	○	○	Broken ribs	○	○
Emphysema	○	○	Any chest injuries or surgeries	○	○
Pneumonia	○	○	Any other lung problem that you've been told about	○	○
Tuberculosis	○	○	If yes, please explain:		

Pulmonary or lung illness symptoms:

Have you **ever** had any of the following symptoms:	Yes	No		Yes	No
Shortness of breath	○	○	Shortness of breath that interferes with your job	○	○
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	○	○	Shortness of breath when walking with other people at an ordinary pace on level ground	○	○
Shortness of breath when washing or dressing yourself	○	○	Have to stop for breath when walking at your own pace on level ground	○	○
Coughing that produces phlegm (thick sputum)	○	○	Coughing that wakes you early in the morning	○	○
Coughing that occurs mostly when you are lying down	○	○	Coughing up blood in the last month	○	○
Wheezing	○	○	Chest pain when you breathe deeply	○	○
Wheezing that interferes with your job	○	○	Any other pulmonary/lung symptoms:	○	○

Supplemental section for Full-Face piece or Self-Contained Breathing Appartus (SCBA) users only *(otherwise please skip & sign)*

Do you currently:	Yes	No		Yes	No
Have vision loss (temporarily or permanently)	○	○	Have color blindness	○	○
Wear glasses	○	○	Have difficulty hearing	○	○
Wear contact lenses	○	○	Wear a hearing aid	○	○
Have weakness in arms, hands, legs or feet	○	○	Have/had ear injury including broken ear drum	○	○
Have difficulty fully moving arms and legs	○	○	Have difficulty fully moving your head up or down	○	○
Have difficulty bending at your knees	○	○	Have difficulty fully moving your head side to side	○	○
Have difficulty squatting to the ground	○	○	Pain/stiffness when leaning at waist (forward or backward)	○	○
Climb stairs/ladder carrying more than 25 lbs.	○	○	Have back pain	○	○
Have/had back injury	○	○	Any other muscle/skeletal/vsion or hearing problems	○	○

Additional Comments: _____

_____

To the best of my knowledge, the information I have provided is true and accurate. **Type Signature*

*Employee Signature:*_____ *Date:* _____ SUBMIT if printing, please email to: OccMedClinic-RiskAssessment@ahc.ufl.edu

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

☐ The mandatory questionnaire has been reviewed

☐ This employee has been found to be physically able to use the following (*check all that apply*):

☐ Single use, filter mask (four attachment points)

☐ Half-faced cartridge-type, negative pressure

☐ Full-faced cartridge-type respirator, negative pressure

☐ Half-faced powered cartridge-type (PAPR)

☐ Full-faced powered cartridge-type (PAPR)

☐ Self-contained breathing apparatus (SCBA)

☐ Hood/helmet powered cartridge-type (PAPR)

☐ Half-faced/Full-faced/Hood/Helmet (NOT positive pressure)

This repirator clearance expires in: ○ 1 ○ 2 ○ 3 years from date indicated below.

Restrictions/Limitations for respirator use *(if applicable)*:_____

☐ There is insufficient information to make a determination at this time

☐ This employee has been found to be physically NOT able to use a respirator

_____ _____ _____

Reviewer's Name (print) Reviewer's Signature Date