HealthPoint
Balance & Well-Being in Work & Life
Occupational Health Program

Employee Name: _____

EID: _____ DOB: _____

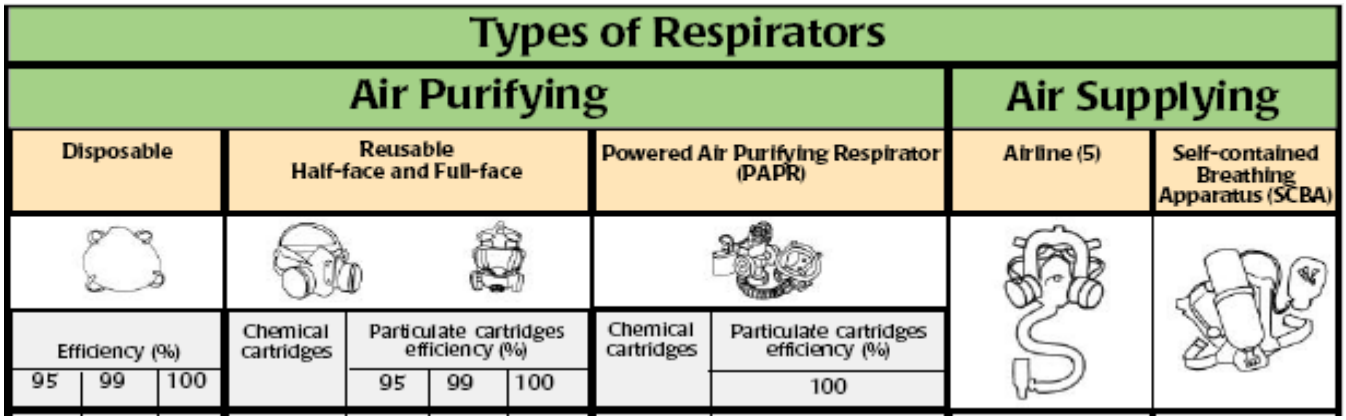
Respiratory Medical Evaluation Questionnaire
Please complete and submit to HealthPoint OHP- Fax: 512-471-2666

Part A: Section 1- Demographics. The following information must be provided by every employee who is required to use a respirator at the University of Texas at Austin as part of their job duties.

Name					Date	
EID			Sex: Male / Female		Date of Birth	
Demographics	Height		Weight		Age (nearest year)	
Dept Name			Bldg.		Job Title	
Work Phone			Shift		Supervisor Name	
Email Contact					Supervisor Phone	

Check the type of respirator you currently wear or plan to wear. Please use the pictures below to help you identify the correct respirator(s). You may check more than one category:

a. ____N, R, or P disposable respirator, e.g. filter–mask, non-cartridge type only (N95)
b. ✓ ____Air Purifying Respirator (APR), e.g. ☑ half or full face piece type, ☐ loose fitting powered-air purifying respirator (PAPR), ☐ tight fitting powered-air purifying respirator (PAPR), ☐ FR-64 gas mask
c. ____Air Supplying Respirator (ASR), e.g. ☐ supplied-air (airline), ☐ self contained breathing apparatus (SCBA)



Have you worn a respirator in the *past*? (circle one): Yes / No If "Yes", what type(s*)*:

_____ _____

Part A: Section 2 – Health Assessment. Questions 1-9 must be answered by every employee who has been selected to use any type of respirator. Questions 10-15 must be answered by ASR and APR respirator users. 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

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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
l. 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
l. Wheezing that interferes with your job:	Yes	No
m. Chest pain when you breath deeply	Yes	No
n. Any other symptoms that you think may be related to lung problems:	Yes	No
5. Have you ***ever had*** any of the following cardiovascular or heart problems?		
a. Heart attack	Yes	No
b. Stroke	Yes	No
c. Angina	Yes	No
d. Heart Failure	Yes	No
e. Swelling in your legs or feet (not caused by walking)	Yes	No
f. Heart arrhythmia (heart beating irregularly	Yes	No
g. High blood pressure	Yes	No
h. Any other heart problem that you've been told about	Yes	No
6. Have you ***ever had*** any of the following cardiovascular or 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	Yes	No
d. In the past two years, have you noticed your heart skipping or missing 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	Yes	No
7. Do you **currently** take medication for any of the following problems?		
a. Breathing or lung problems	Yes	No
b. Heart trouble	Yes	No
c. Blood pressure	Yes	No
d. Seizures (fits):	Yes	No
List medications:		

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8. If you have used a respirator, have you **ever had** any of the following problems? (**If you have never used a respirator**, check the following space and go to question 9): _____		
a. Eye irritation	Yes	No
b. Skin allergies or rashes	Yes	No
c. Anxiety	Yes	No
d. General weakness or fatigue	Yes	No
e. Any other problem that interferes with your use of a respirators	Yes	No
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? HealthPoint OHP – Phone: 471-4OHP(4647) or HealthPoint.OHP@austin.utexas.edu	Yes	No
10. Have you *ever* lost vision in either eye (temporarily or permanently?	Yes	No
11. Do you *currently* have any of the following vision problems?		
a. Wear contact lenses	Yes	No
b. Wear glasses	Yes	No
c. Color blind	Yes	No
d. Any other eye or vision problem	Yes	No
12. Have you *ever had* an injury to your ears, including a broken eardrum?	Yes	No
13. Do you *currently* have any of the following hearing problems?		
a. Difficulty hearing	Yes	No
b. Wear a hearing aid	Yes	No
c. Any other hearing or ear problem	Yes	No
14. Have you **ever** had a back injury?	Yes	No
15. Do you **currently** have any of the following musculo-skeletal problems?		
a. Weakness in any of your arms, hands, legs or feet	Yes	No
b. Difficulty fully moving your arms and legs	Yes	No
c. Pain or stiffness when you lean forward or backward at the waist	Yes	No
d. Difficulty fully moving your head up or down	Yes	No
e. Difficulty fully moving head side to side	Yes	No
f. Difficulty bending at your knees	Yes	No
g. Difficulty squatting to the ground	Yes	No
h. Climbing a flight or stairs or a ladder carrying more that 25 lbs	Yes	No
i. Any other muscle or skeletal problem that interferes with using a respirator	Yes	No
j. Back pain If you answered "Yes", please answer the following: Specify where it hurts:_____ How often: ☐ daily ☐ weekly ☐ monthly ☐ periodically – occasional flare-ups	Yes	No
k. Do you take medication for back pain If "yes", please list:	Yes	No

Part B: Work Environment & Work History - Please answer the following questions:

1. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals? If you answered "Yes", name the chemicals if you know them: _____ _____	Yes	No
2. Have you ever worked with any of the materials, or under any of the conditions listed below?		
a. Asbestos	Yes	No
b. Silica (e.g., in the sandblasting)	Yes	No
c. Tungsten/cobalt (e.g., grinding or welding this material)	Yes	No

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d. Beryllium	Yes	No
e. Aluminum	Yes	No
f. Coal (for example, mining)	Yes	No
g. Iron	Yes	No
h. Tin	Yes	No
i. Dusty environments	Yes	No
j. Any other hazardous exposures If you answered "Yes", describe these exposures: _____	Yes	No
3. List any second jobs or side businesses you have:		
4. List your previous occupations:		
5. List your current and previous hobbies:		
6. Have you been in the military services?	Yes	No
If you answered "YES", were you exposed to biological or chemical agents (either in training or combat)? Name the agents:	Yes	No
7. Have you ever worked on a HAZMAT team? Where & When:	Yes	No
8. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over the counter medications)? If you answered "Yes," name the medications if you know them:	Yes	No
9. Will you be using any of the following items with your respirator(s)?		
a. HEPA filters	Yes	No
b. Canisters (for example, gas masks)	Yes	No
c. Cartridges	Yes ✓	No
10. How often are you expected to use the respirator(s)? (Circle "Yes" or "No" for all answers that apply to you)		
a. Escape only (no rescue)	Yes	No
b. Emergency rescue only	Yes	No
c. HAZMAT response	Yes	No
d. Less than 5 hours per week	Yes	No
e. Less than 2 hours per day	Yes	No
f. 2 to 4 hours per day	Yes	No
g. Over 4 hours per day	Yes	No
11. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator? If you answered "Yes", describe this protective clothing and/or equipment: Eye protection (goggles, faceshield), hearing protection (ear plugs, ear muffs), Skin protection (apron, coveralls, tyvek suits), gloves	Yes ✓	No
12. Will you be working under hot conditions (temperature exceeding 77 degrees F)?	Yes	No

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13. Will you be working under humid conditions?	Yes	No

14. Describe any special or hazardous conditions you might encounter when you're using your respirator(s).
(For example: confined spaces, life-threatening gases):

15. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the toxic substance(s): acetone, n-butyl acetate, ethyl acetate, isobutyl acetate, isopropyl alcohol, methyl chloride, mineral spirits, petroleum distillates (naptha), propane, 2,4,6-trinitrophenol, xylene (o-,m-,p- isomers) dusts- fly ash- particulates- fibers, solvents (benzene, toluene, xylene) aluminum (welding fumes), amonia, butane, coal dust (anthracite), toxic gases, fumes (welding, organic chemicals

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

16. Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well being of others (For example: rescue, confined space, HAZMAT, etc.):

Nurse Reviewer: Date of Review: