University of California, Davis

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OCCUPATIONAL HEALTH SERVICES
One Shields Avenue
Davis, CA 95616-8764
(530) 752-6051; Fax (530) 752-5277

Periodic Evaluation for Respirator Use (non-SCBA users)
Employee Medical Questionnaire (OSHA Mandated Evaluation Questionnaire)

Name:______________________________ Date of Birth:________________ Age: ___________

Employee ID:___________________________________ Today's Date: ______________________

Address: ____ Phone #________________

To the employee – Can you read (check one): ☐ Yes ☐ No

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 you employer must tell you how to deliver or send this questionnaire to the health care professional who will review it. For the University of California Davis Campus, the reviewing health care provider is located at Occupational Health Services (530-752-6051). Your supervisor will also need to complete a Request and Authorization form authorizing the review of this questionnaire and sent it to Occupational Health Services. The questionnaire should be faxed to Occupational Health Services (fax: 530-752-5277). Both the questionnaire and authorization form must be received and reviewed **prior** to scheduling a fitting appointment. Do not give the completed questionnaire to your supervisor.

Section 1

Every employee required to use any type of respirator must provide the following information (please print).

1. Gender identity (check one): Male Female Transgender Genderqueer Nonbinary Other gender identity

2. Height: ft. in. Weight: lbs.

4. Job Title Dept:

5. Phone # that the reviewing health care professional can call you (include Area Code):________________________
6. The best time to phone you at the number? _________________________
7. Check the type(s) of respirator you will use:

a.	N, R, or P disposable respirator (filter-mask, non-cartridge type only)	Yes	No
b.	Half or Full-face piece type	Yes	No
c.	Powered-air purifying, supplied air	Yes	No
d.	Self-contained breathing apparatus	Yes	No

If yes, what type(s)?

a. N, R, or P disposable respirator (filter-mask, non-cartridge type only)	Yes	No
b. Half- or full-face piece type	Yes	No
c. Powered-air purifying, supplied-air	Yes	No
d. Self-contained breathing apparatus	Yes	No

Section 2

Question	Yes	No
1. Do you currently smoke tobacco, vape or use e-cigarettes or have you smoked tobacco, vaped or used e-cigarettes 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. Any other lung problem that you have been told about	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. Asthma	Yes	No
1. Have you been treated in a healthcare setting for an asthma flare-up?	Yes	No
2. If yes how long ago was the flare-up? ___________________________		
3. Do you have a rescue inhaler?	Yes	No
4. If yes when was the last time you used it? ______________________		
5. What medication are you taking for breathing or lung problems? _____________________________		
4. Do you currently have any of the following syptoms 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 your breathe 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?

	Yes	No
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	Yes	No
g. High blood pressure	Yes	No
h. Any other heart problem that you have been told about	Yes	No

6. Have you ever had any of the following cardiovascular or heart symptoms?

	Yes	No
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?

	Yes	No
a. Breathing or lung problems	Yes	No
b. Heart trouble	Yes	No
c. Blood pressure	Yes	No
d. Seizures (fits)	Yes	No

8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check "no" for all and go to question 9.)

	Yes	No
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 respirator	Yes	No

9. Would you like to talk to the health care professional about your answers to this questionnaire? Yes | No