UNIVERSITY OF CALIFORNIA, DAVIS MEDICAL CENTER
EMPLOYEE HEALTH SERVICES

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE - N95 (RESPIRATORY ISOLATION MASK)

APPENDIX C TO SEC.1910.134: OSHA RESPIRATORY MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY)

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 your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

NOTE TO EMPLOYEE: SEND THIS FORM DIRECTLY TO EMPLOYEE HEALTH SERVICES. SCAN/EMAIL IS PREFERRED. KEEP A COPY FOR YOUR RECORDS. EMAIL TO: employee.health@ucdmc.ucdavis.edu

NAME:	**DOB:**	**AGE:**	**DATE:**
GENDER: ☐ MALE ☐ FEMALE	**HEIGHT: _____ WEIGHT:_____**		
HOME/CELL PHONE:	**DEPARTMENT:**	**JOB TITLE:**	

PART A SECTION 1. (MANDATORY) THE FOLLOWING INFORMATION MUST BE PROVIDED BY EVERY EMPLOYEE.

1.	**Has your employer told you how to contact the health care professional who will review this questionnaire?**	☐ Yes ☐ No
2.	**Have you worn a respirator?** If YES, what type:	☐ Yes ☐ No

PART A SECTION 2 (MANDATORY) QUESTIONS 1 THROUGH 10 BELOW MUST BE ANSWERED BY EVERY EMPLOYEE. (please indicate "YES" OR "NO") If any YES, please explain. (Please print)

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?**	
2a.	Seizures (fits) If YES, please explain:	☐ Yes ☐ No
2b.	Diabetes (sugar disease) If YES, please explain:	☐ Yes ☐ No
2c.	Allergic reactions that interfere with your breathing If YES, please explain:	☐ Yes ☐ No
2d.	Claustrophobia (fear of closed-in places) If YES, please explain:	☐ Yes ☐ No
2e.	Trouble smelling odors If YES, please explain:	☐ Yes ☐ No
3.	**Have you ever had any of the following pulmonary or lung problems?**	
3a.	Asbestosis If YES, please explain:	☐ Yes ☐ No
3b.	Asthma If YES, please explain:	☐ Yes ☐ No
3c.	Chronic bronchitis If YES, please explain:	☐ Yes ☐ No
3d.	Emphysema If YES, please explain:	☐ Yes ☐ No

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3e.	Pneumonia If YES, please explain:	☐ Yes ☐ No
3f.	Tuberculosis If YES, please explain:	☐ Yes ☐ No
3g.	Silicosis If YES, please explain:	☐ Yes ☐ No
3h.	Pneumothorax (collapsed lung) If YES, please explain:	☐ Yes ☐ No
3i.	Lung cancer If YES, please explain:	☐ Yes ☐ No
3j.	Broken ribs If YES, please explain:	☐ Yes ☐ No
3k.	Any chest injuries or surgeries If YES, please explain:	☐ Yes ☐ No
3l.	Any chest lung problem that you've been told about If YES, please explain:	☐ Yes ☐ No
4.	**Do you currently have any of the following symptoms of pulmonary or lung illness?**	
4a.	Shortness of breath If YES, please explain:	☐ Yes ☐ No
4b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline If YES, please explain:	☐ Yes ☐ No
4c.	Shortness of breath when walking with other people at an ordinary pace on level ground If YES, please explain:	☐ Yes ☐ No
4d.	Have to stop for breath when walking at your own pace on level ground If YES, please explain:	☐ Yes ☐ No
4e.	Shortness of breath when washing or dressing yourself If YES, please explain:	☐ Yes ☐ No
4f.	Shortness of breath that interferes with your job If YES, please explain::	☐ Yes ☐ No
4g.	Coughing that produces phlegm (thick sputum) If YES, please explain::	☐ Yes ☐ No
4h.	Coughing that wakes you early in the morning If YES, please explain:	☐ Yes ☐ No
4i.	Coughing that occurs mostly when you are laying down If YES, please explain:	☐ Yes ☐ No
4j.	Coughing up blood in the last month I If YES, please explain:	☐ Yes ☐ No
4k.	Wheezing If YES, please explain:	☐ Yes ☐ No
4l.	Wheezing that interferes with your job If YES, please explain:	☐ Yes ☐ No
4m.	Chest pain when you breathe deeply If YES, please explain:	☐ Yes ☐ No
4n.	Any other symptoms that you think may be related to lung problems If YES, please explain:	☐ Yes ☐ No

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4o.	Do you have uncontrolled thyroid problems If YES, please explain:	☐ Yes ☐ No
4p.	Do you have problems with temperature regulations If YES, please explain:	☐ Yes ☐ No
4q.	Have you ever had "heat" stroke If YES, please explain::	☐ Yes ☐ No
4r.	Do you have history of heat intolerance If YES, please explain:	☐ Yes ☐ No
5.	**Have you ever had any of the following cardiovascular or heart problems?**	
5a.	Heart attack If YES, please explain:	☐ Yes ☐ No
5b.	Stroke If YES, please explain:	☐ Yes ☐ No
5c.	Angina If YES, please explain:	☐ Yes ☐ No
5d.	Heart failure If YES, please explain:	☐ Yes ☐ No
5e.	Swelling in your legs or feet (not caused by walking) If YES, please explain:	☐ Yes ☐ No
5f.	Heart arrthymia (heart beating irregularly) If YES, please explain:	☐ Yes ☐ No
5g.	High blood pressure If YES, please explain:	☐ Yes ☐ No
5h.	Any other symptoms that you can think may be related to lung If YES, please explain:	☐ Yes ☐ No
6.	**Have you ever had any of the following cardiovascular or heart symptoms?**	
6a.	Frequent pain or tightness in your chest If YES, please explain:	☐ Yes ☐ No
6b.	Pain or tightness in your chest during physical activity If YES, please explain:	☐ Yes ☐ No
6c.	Pain or tightness in your chest that interferes with your job If YES, please explain:	☐ Yes ☐ No
6d.	In the past two years, have you noticed your heart skipping or missing a beat If YES, please explain::	☐ Yes ☐ No
6e.	Heartburn or indigestion that is not related to eating If YES, please explain:	☐ Yes ☐ No
6.f	Any other symptoms that you think may be related to heart or circulation problems If YES, please explain:	☐Yes ☐ No
7.	**Do you currently take medication for any of the following problems?**	
7a.	Breathing or lung problems If YES, list medications:	☐ Yes ☐ No
7b.	Heart trouble If YES, list medications:	☐ Yes ☐ No
7c.	Blood pressure If YES, list medications:	☐ Yes ☐ No

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7d.	Seizures If YES, list medications:	☐ Yes ☐ No
7e.	**List any other medications:**	
8.	**(If you've never used a respirator, check never used and go to question #9)** **Have you ever had any of the following problems while using a respirator?**	☐ Never used
8a.	Eye irritation If YES, please explain:	☐ Yes ☐ No
8b.	Skin allergies or rashes If YES, please explain:	☐ Yes ☐ No
8c.	Anxiety If YES, please explain:	☐ Yes ☐ No
8d.	General weakness or fatigue If YES, please explain:	☐ Yes ☐ No
8e.	Seizures (fits) If YES, please explain::	☐ Yes ☐ No
9.	**Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?**	☐ Yes ☐ No
**************************BELOW SECTION EHS STAFF ONLY**************************		
☐	**Employee is cleared to perform job duties with use of a respirator**	
☐	**Employee needs an appointment with employee health service for further evaluation**	
☐	**Other recommendations:**	
It should be noted that medical qualification for respirator use is dependent upon proper fit testing and instruction regarding use and maintenance of respiratory equipment.		
Nurse OR Physician Signature:		**Date:**