THE UNIVERSITY OF CHICAGO

Environmental Health and Safety
5235 South Harper Court
Chicago, Illinois 60615
773.702.9999 or safety@uchicago.edu

Annual Respirator Questionnaire Directions

Please Note Do not complete this form unless your job task has been reviewed by Environmental Health and Safety (EHS) or the Office of Research Safety (ORS).*

Employee

- **Complete** Medical Qualification Questionnaire.
- **Sign** the bottom of the questionnaire.
- **Seal** in an envelope.
  - **Mark** confidential on the front of the envelope.
  - **Write** your name, department and phone number on the back of the envelope.
- **Return** the sealed envelope to **your supervisor.**

Supervisor

- **Add** your name and phone number on back of the envelope.
- **Send** the sealed envelope to **University of Chicago Occupational Medicine Group (UCOM – D-136)** along with a payment for review of the OSHA Medical History Form.
- If a follow-up physical is necessary, the department will be contacted directly to schedule the follow-up physical and provide additional payment.

UCOM

- Contact employees directly for clarification on any questions.
- Contact departments directly for scheduling follow-up physicals.
- Send all clearance forms to EHS (Fax: 773.702.6546).

Safety Office

- Update employee training records.

Departments

- Employees who have not been medically cleared will **NOT** be allowed to attend the training session.
- Departments are responsible for purchasing the appropriate respirator and cartridges as identified on the fit test record.

Note: **If you have questions regarding the review of this questionnaire, you may contact UCOM at 773.702.6757.**

University of Chicago Medical Center Occupational Medicine (UCOM)
5841 S. Maryland Ave. Room D-136 Chicago, Illinois 60637
773.702.6757 fax 773.834.9106 or fax 773.834.9189

Medical Evaluation Questionnaire for Respirator Use

Employee Name:_____ Today's Date: _____

Social Security Number:_____ Date of Birth:_____ Check one: ❒ Female ❒ Male

Job Title: _____ Cost Center #: _____ Supervisor: _____

Your Height: _____ Your weight: _____

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.

A phone number where you can be reached by Occupational Medicine (include Area Code): _____
The best time to phone you at this number: _____ am/pm
Has your employer told you how to contact Occupational Medicine ❒ yes ❒ no

Type of respirator you will use (check all that apply):
❒ N95 (orange mask) ❒ Mask ❒ Full-Face ❒ Powered air purifying respirator (PAPR)

Have you worn a respirator: ❒ yes ❒ no If yes, what type(s)?
Did you experience any problems wearing a respirator? ❒ yes ❒ no If yes, please explain:

MEDICAL HISTORY					
1. Smoking History ❒ Current smoker ❒ Ex-smoker ❒ Never smoked					
Have you ever had any of the following conditions?					
2. Seizures (fits)?	Yes	No	3. Diabetes?	Yes	No
4. Trouble smelling odors?	Yes	No	5. Claustrophobia or fear of small places?	Yes	No
6. Allergic reactions that interfere with your breathing?	Yes	No	7. Do you currently take any medication for seizures?	Yes	No
Have you ever had any of the following pulmonary or lung problems?					
8. Asbestosis	Yes	No	9. Asthma	Yes	No
10. Chronic Bronchitis	Yes	No	11. Emphysema	Yes	No
12. Pneumonia	Yes	No	13. Tuberculosis	Yes	No
14. Silicosis	Yes	No	15. Pneumothorax (collapsed lung)	Yes	No
16. Lung Cancer	Yes	No	17. Broken ribs	Yes	No
18. Any chest injuries or surgeries	Yes	No	19. Any other lung problem that you've been told about?	Yes	No

Do you currently have any of these symptoms of pulmonary or lung disease?					
20. Shortness of Breath	Yes	No	21. Shortness of breath with when walking fast on level ground or walking up a slight hill?	Yes	No
22. Shortness of breath when walking with other people at an ordinary pace on level ground?	Yes	No	23. Have to stop for breath when walking at your own pace on level ground	Yes	No
24. Shortness of breath when washing or dressing yourself	Yes	No	25. 26. Shortness of breath that interferes with your job?	Yes	No
27. Coughing that produces phlegm (thick sputum)	Yes	No	28. Coughing that wakes you in the early morning?	Yes	No
29. Coughing that occurs mostly when you are lying down?	Yes	No	30. Coughing up blood in the last month	Yes	No
31. Wheezing	Yes	No	32. Wheezing that interferes with your job	Yes	No
33. Chest pain when you breath deeply	Yes	No	34. Any other lung problem that you've been told about?	Yes	No
35. Do you currently take any medication for Heart trouble?	Yes	No	36. Do you currently take any medication for high blood pressure?	Yes	No
Have you ever had any of the following cardiovascular or heart problems:					
37. Heart attack	Yes	No	38. Stroke	Yes	No
39. Angina	Yes	No	40. Heart failure	Yes	No
41. Heart arrhythmia (irregular heart beat)	Yes	No	42. High blood pressure	Yes	No
43. Any other heart problem that you've been told about	Yes	No	44. Do you currently take any medications for heart trouble or blood clots	Yes	No
45. Swelling in your legs or feet (not caused by walking)?	Yes	No			
Have you ever had any of these cardiovascular or heart symptoms?					
46. Frequent pain or tightness in your chest	Yes	No	47. Pain or tightness in your chest during physical activity	Yes	No
48. Pain or tightness in your chest that interfere with your job	Yes	No	49. In the past two years, have you noticed your heart skipping or missing a beat	Yes	No
50. Heartburn or indigestion that is not related t eating	Yes	No	51. Any other symptoms you think may be related to heart or circulatory problems	Yes	No
If you've NEVER USED A RESPIRATOR, check this box ❒ and go to Employee Signature **If you HAVE used a respirator in the past, have you ever had any of the following problems?**					
52. Eye irritation?	Yes	No	53. Skin allergies or rashes?	Yes	No
54. Anxiety	Yes	No	55. General weakness or fatigue?	Yes	No
56. Any other problem that interferes with your use of a respirator?	Yes	No	57. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	Yes	No

Print Name: Signature: Date:

Reviewed by: Signature: Date: