

**Employee Health Divisions**

**Mills Pen:** 650-696-5034 (Ph)

650-696-5160 (Fax)

**Palo Alto:** 650-853-2970 (Ph)

650-853-2022 (Fax)

**Alameda:** 510-498-2680 (Ph)

510-498-2818 (Fax)

**Camino:** 408-730-4302 (Ph)

408-523-3729 (Fax)

**Santa Cruz:** 831-458-6361 (Ph)

831-462-7196 (Fax)

**Employee Health Department Screening**

Respirator Medical Evaluation Form

Adapted from appendix C to Sec. 1910.134:

OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

**Employee Health Screening Clinic Provider Only**

FAILED SCREENING  PASSED SCREENING (able to do Fit Test)

Date       Provider Initials       Date       Provider Initials

Patient Notified By       Date       Electronic Entry By       Date

Notes

**Please complete this form and submit to Employee Health**

**before scheduling your respirator fit test.**

**AFTER COMPLETING PAGE 2, FAX OR RETURN FORM TO SENDER’S E-MAIL ADDRESS.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PHYSICIAN OR EMPLOYEE INFORMATION** | | | | |
| **Print Your Name** | | **Job Title and Location** | | **Today’s Date** |
| Date of Birth | Sex (CHECK ONE)  Male  Female | Height          Ft.       in | Weight        lbs | Day time Phone including area code  (      ) |
| Have you worn a respirator (CHECK ONE)  Yes  No | | | | |
| If “Yes” what type(s): **CHECK ONE:**  PAPR  N-95 KC Small  N-95 KC Reg  N-95 3M Small  N-95 3M Reg  KC = Kimberly Clark  Moldex 2300 N95 Small  Moldex 2301N95 Med/Lrg  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| |  |  |  | | --- | --- | --- | | **In the past year have you experienced / sustained the following:** | Yes | No | | Weight gain or loss of ten pounds or more? |  |  | | Dental procedures/surgery such as implants or bridges? |  |  | | Facial or jaw surgery? |  |  | | Facial hair growth (beard)? |  |  | | | | | |
| **PLEASE GO TO PAGE 2 AND ANSWER QUESTIONS 1-9 BEFORE SCHEDULING YOUR FIT TEST.** | | | | |

**Please check "Yes" or "No".** **Explain any “YES” answers in Box 10.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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?** | | | | |  |  |
|  | **Yes** | **No** |  | | **Yes** | **No** |
| Seizures |  |  | Claustrophobia (fear of closed-in places) | |  |  |
| Allergic reactions that interfere with your breathing |  |  | Trouble smelling odors | |  |  |
| **3. Have you ever had or currently have any of the following pulmonary or lung problems?** | | | | | | |
|  | **Yes** | **No** | |  | **Yes** | **No** |
| Asbestosis/Silicosis/ Tuberculosis/ Lung Cancer |  |  | | Broken ribs/ Any chest injuries or surgeries |  |  |
| Asthma/Chronic bronchitis/Emphysema/ Pneumonia |  |  | | Any other lung problem that you've been told about |  |  |
| Pneumothorax (collapsed lung) |  |  | | Diabetes |  |  |
| **4. Do you currently have any of the following pulmonary or lung problems?** | | | | | | |
|  | **Yes** | **No** | |  | **Yes** | **No** |
| Shortness of breath/wheezing |  |  | | Chest pain when you breathe deeply |  |  |
| Shortness of breath when walking fast on level ground or walking up slight hill/incline |  |  | | Coughing that produces phlegm (thick mucous |  |  |
| Shortness of breath when walking with other people at an ordinary pace on level ground |  |  | | Coughing that occurs mostly when you are lying down |  |  |
| Have to stop for breath when walking at your own pace on level ground |  |  | | Coughing that wakes you early in the morning: |  |  |
| Shortness of breath when washing or dressing yourself |  |  | | Coughing up blood in the last month |  |  |
| Shortness of breath/wheezing that interferes with your job |  |  | | Any other symptoms that you think may be related to lung problems |  |  |
| **5. Have you ever had any of the following cardiovascular or heart problems?** | | | | | | |
|  | **Yes** | **No** | |  | **Yes** | **No** |
| Heart attack |  |  | | Stroke |  |  |
| Angina |  |  | | Heart failure |  |  |
| Heart arrhythmia (heart beating irregularly): |  |  | | High blood pressure |  |  |
| Swelling in your legs or feet (not caused by walking): |  |  | | Any other heart problem that you've been told about |  |  |
| **6. Have you ever had any of the following cardiovascular or heart symptoms?** | | | | | | |
|  | **Yes** | **No** | |  | **Yes** | **No** |
| Frequent pain or tightness in your chest |  |  | | In the past two years, have you noticed your heart skipping or missing a beat |  |  |
| Pain or tightness in your chest during physical activity |  |  | | Heartburn or indigestion that is not related to eating |  |  |
| Pain or tightness in your chest that interferes with your job |  |  | | Any other symptoms that you think may be related to heart or circulation problems |  |  |
| **7. Do you currently take medication for any of the following problems?** | | | | | | |
|  | **Yes** | **No** | |  | **Yes** | **No** |
| Breathing or lung problems |  |  | | Heart trouble |  |  |
| Blood pressure |  |  | | Seizures (fits): |  |  |
| **8. (If you've never used a respirator, check the following space and go to question 9)**  **If you've used a respirator, have you ever had any of the following problems?** | | | | | | |
|  | **Yes** | **No** | |  | **Yes** | **No** |
| Eye irritation |  |  | | General weakness or fatigue |  |  |
| Anxiety |  |  | | Problems wearing a respirator |  |  |
| Skin allergies or rashes |  |  | | A medical or other problem that might interfere with respirator use |  |  |
| **9. Would you like to talk to the health care professional who will review this**  **Questionnaire about your answers to this questionnaire?** | | | | | **Yes** | **No** |
| **EXPLANATIONS TO ANY ‘YES’ ANSWERS**  **10.** Click here to enter text. | | | | | | |

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