

**Employee Health Divisions**

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

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

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

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 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)? |  |  |

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| **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.  |

**FAX OR RETURN FORM TO SENDER’S E-MAIL ADDRESS.**