UAB CAMPUS EMPLOYEE
Initial Respirator Use Form

Date: __________ Name: ____________________________ Blazer ID: ________________

Work Phone: __________ Work Location: Building ____________ Room________

Supervisor: ____________________________ Job Title: ____________________________

Age: _____ Male _____ Female _____ Height: _____ ft _____ in  Weight: _____ lbs

Describe your work that requires respirator use: ____________________________________________

1. Circle the type of respirator you will be using (you can circle more than one category):
   N-95  N-99  N-100
   Half-Face Piece Type Respirator  Full-Face Piece Type Respirator  Powered-Air Purifying Respirator
   Self-Contained Breathing Apparatus

2. Have you ever worn a respirator? ................................................................. YES  NO

3. Do you currently smoke tobacco or have you smoked tobacco in the last month? …

4. 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........................................................................................................... YES  NO
   E. Trouble smelling odors............................................................................................. YES  NO

5. Have you ever had any of the following pulmonary or lung problems?
   A. Asbestosis................................................................................................................ YES  NO
   B. Asthma....................................................................................................................... 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. Any other lung problem that you’ve been told about.................................................... YES  NO

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6. Do you currently have any of the following symptoms of pulmonary or lung illness?
   A. Shortness of breath………………………………………………………
   □ □
   B. Shortness of breath when walking fast on level ground or up a slight hill or incline…
   □ □
   C. Shortness of breath when walking with other people at an ordinary pace on level
      Ground
   □ □
   D. Have to stop for breath when walking at your own pace on level ground……………
   □ □
   E. Shortness of breath when washing or dressing yourself…………………………
   □ □
   F. Shortness of breath that interferes with your job……………………………………
   □ □
   G. Coughing that produces phlegm (thick sputum)…………………………………
   □ □
   H. Coughing that wakes you early in the morning……………………………………
   □ □
   I. Coughing that occurs mostly when you are lying down…………………………
   □ □
   J. Coughing up blood in the last month…………………………………………
   □ □
   K. Wheezing……………………………………………………………………
   □ □
   L. Wheezing that interferes with your job………………………………………..
   □ □
   M. Chest pain when you breathe deeply…………………………………………
   □ □
   N. Any other symptoms that you think may be related to lung problems…………
   □ □

7. Have you ever had any of the following cardiovascular or heart problems?
   A. Heart attack…………………………………………………………………
   □ □
   B. Stroke…………………………………………………………………………
   □ □
   C. Angina…………………………………………………………………………
   □ □
   D. Heart failure……………………………………………………………………
   □ □
   E. Swelling in your legs or feet……………………………………………………
   □ □
   F. Heart arrhythmia (heart beating irregularly)……………………………………
   □ □
   G. High blood pressure…………………………………………………………
   □ □
   H. Any other heart problem that you’ve been told about…………………………
   □ □

8. Have you ever had any of the following cardiovascular or heart symptoms?
   A. Frequent pain or tightness in your chest…………………………………….
   □ □
   B. Pain or tightness in your chest during physical activity…………………………
   □ □
   C. Pain or tightness in your chest that interferes with your job……………………
   □ □
   D. In the past two years, have you noticed your heart skipping or missing a beat……
   □ □
   E. Heartburn or indigestion that is not related to eating…………………………
   □ □
   F. Any other symptoms that you think may be related to heart or circulation problems.
   □ □

9. Do you currently take medication for any of the following problems?
   A. Breathing or lung problems…………………………………………………
   □ □
   B. Heart trouble…………………………………………………………………
   □ □
   C. Blood pressure………………………………………………………………
   □ □
   D. Seizures (fits)……………………………………………………………………
   □ □

10. If you’ve used a respirator, have you ever had any of the following problems?
    A. I have never used a respirator (go to Question 11)…………………………
    □ □
    B. Eye irritation…………………………………………………………………
    □ □
    C. Skin allergies or rashes…………………………………………………………
    □ □
    D. Anxiety…………………………………………………………………………
    □ □
    E. General weakness or fatigue………………………………………………...
    □ □
    F. Any other problem that interferes with your use of a respirator………………
    □ □

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11. Will you be wearing a full-face piece respirator OR a self contained breathing apparatus (SCBA)? If YES, please answer the following questions. If NO, continue to question 12.

   YES  □  NO  □

   A. Have you ever lost vision in either eye (temporarily or permanently)?............. □  □

   B. Do you currently have any of the following vision problems?
      1. Wear contact lenses...........................................................................................................
         □  □
      2. Wear glasses....................................................................................................................
         □  □
      3. Color blind.....................................................................................................................
         □  □
      4. Any other eye or vision problem:____________________________________________________
         □  □

   C. Have you ever had an injury to your ears, including a broken ear drum?.............. □  □

   D. Do you currently have any of the following hearing problems?
      1. Difficulty hearing............................................................................................................
         □  □
      2. Wear a hearing aid...........................................................................................................
         □  □
      3. Any other hearing or ear problem:__________________________________________________
         □  □

   E. Have you ever had a back injury?.................................................................................. □  □

   F. Do you currently have any of the following musculoskeletal problems?
      1. Weakness in any of your arms, hands, legs or feet...................................................... □  □
      2. Back pain......................................................................................................................
         □  □
      3. Difficulty fully moving your arms or legs......................................................................
         □  □
      4. Pain or stiffness when you lean forward or backward at the waist...........................
         □  □
      5. Difficulty fully moving your head up or down.............................................................
         □  □
      6. Difficulty fully moving your head side to side.............................................................
         □  □
      7. Difficulty bending at your knees...................................................................................
         □  □
      8. Difficulty squatting to the ground................................................................................
         □  □
      9. Climbing a flight of stairs or a ladder carrying more than 25 pounds....................... □  □
     10. Any other muscle or skeletal problem that interferes with using a respirator...........
         □  □

12. Would you like to talk to the health care professional who will review your answers on this questionnaire?........................................................................................................ □  □

Employee Signature  ____________________________________________________________
Date  __________

Health Care Professional Approval  __________________________________________________
Date  __________

If electronically submitted, the form must be sent from the employee’s UAB email account to satisfy the signature requirement.

Form submittal:
1. You may submit completed forms electronically to OHSoccmmed@uab.edu. This is preferred.
2. You may place the completed forms in a Confidential Envelop and return it to:
   UAB OH&S Occupational Medicine
   CH19, Suite 445-2041
1. You may fax the completed forms to (205) 934-7487. Please be aware that the fax machine is located in the main OH&S office and confidentiality cannot be assured.
2. You may deliver your completed forms to CH19 Suite 412 and place them in the secured lock box at the receptionist desk.