APPENDIX III

CONFIDENTIAL

OCCUPATIONAL HEALTH CLINIC RESPIRATORY PROTECTION QUESTIONNAIRE
PART ONE - MANDATORY FOR ALL UC Berkeley RESPIRATOR USERS

Can you read English? □Yes □No

This questionnaire must be completed by all Campus employees who will be using any respiratory protection at work. Your department 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, no one, including your supervisor, may look at or review your answers without your permission. Please bring the completed questionnaire to your respiratory protection medical examination at the University Health Services Occupational Health Clinic (510-642-6891).

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: □ Male □ Female

Height: _____ Weight: _____

Department: _____ Job Title: _____

Home Phone: (_____) _____ Best time to reach you there: _____

Work Phone: (_____) _____ Best time to reach you there: _____

Check the type of respirator will you use:

□ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
□ Other type (such as half- or full-face, supplied-air, SCBA, etc.)

Have you worn a respirator before? □No □Yes, type: _____

MEDICAL HISTORY

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?
   a. Seizures: Yes□ No□
   b. Diabetes (sugar disease): Yes□ No□
   c. Allergic reactions that interfere with your breathing: Yes□ No□
   d. Claustrophobia (fear of closed-in places): Yes□ No□
   e. Trouble smelling odors: Yes□ No□

3. 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□

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

a.	Shortness of breath:	Yes□	No□
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	Yes□	No□
c.	Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes□	No□
d.	Have to stop for breath when walking at your own pace on level ground:	Yes□	No□
e.	Shortness of breath when washing or dressing yourself:	Yes□	No□
f.	Shortness of breath that interferes with your job:	Yes□	No□
g.	Coughing that produces phlegm (thick sputum):	Yes□	No□
h.	Coughing that wakes you early in the morning:	Yes□	No□
I.	Coughing that occurs mostly when you are lying down:	Yes□	No□
j.	Coughing up blood in the last month:	Yes□	No□
k.	Wheezing:	Yes□	No□
l.	Wheezing that interferes with your job:	Yes□	No□
m.	Chest pain when you breathe deeply:	Yes□	No□
n.	Any other symptoms that you think may be related to lung problems:	Yes□	No□

5. Have you ever had any of the following cardiovascular or heart problems?

a.	Heart attack:	Yes□	No□
b.	Stroke:	Yes□	No□
c.	Angina:	Yes□	No□
d.	Heart failure:	Yes□	No□
e.	Swelling in your legs or feet (not caused by walking):	Yes□	No□
f.	Heart arrhythmia (heart beating irregularly):	Yes□	No□
g.	High blood pressure:	Yes□	No□
h.	Any other heart problem that you've been told about:	Yes□	No□

6. Have you ever had any of the following cardiovascular or heart symptoms?

a.	Frequent pain or tightness in your chest:	Yes□	No□
b.	Pain or tightness in your chest during physical activity:	Yes□	No□
c.	Pain or tightness in your chest that interferes with your job:	Yes□	No□
d.	In the past two years, have you noticed your heart skipping or missing a beat:	Yes□	No□
e.	Heartburn or indigestion that is not related to eating:	Yes□	No□
f.	Any other symptoms that you think may be related to heart or circulation problems:	Yes□	No□

7. Do you currently take medication for any of the following problems?

a.	Breathing or lung problems:	Yes□	No□
b.	Heart trouble:	Yes□	No□

c. Blood pressure: Yes☐ No☐
d. Seizures (fits): Yes☐ No☐

8. If you have used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check here_____.)
   a. Eye irritation: Yes☐ No☐
   b. Skin allergies or rashes: Yes☐ No☐
   c. Anxiety: Yes☐ No☐
   d. General weakness or fatigue: Yes☐ No☐
   e. Any other problem that interferes with your use of a respirator: Yes☐ No☐

If you will be using a full face respirator or a self-contained breathing apparatus, please complete Part II of this questionnaire.

Thank you for completing this questionnaire. Your questionnaire will be reviewed with a clinician at the time of your medical examination at the Occupational Health Clinic. Contingent on your answers and your medical examination, further information about your health and your use of a respirator may be required. If you would like to talk with one of our nurses prior to your appointment, please feel free to call us at 510-642-6891. We are available 8 to 11:45 and 1 to 4:45 weekdays.

PART TWO
MANDATORY FOR ALL UC BERKELEY FULL-FACE RESPIRATOR AND SELF-CONTAINED BREATHING APPARATUS (SCBA) USERS

1.	Have you ever lost vision in either eye (temporarily or permanently):	Yes☐	No☐
2.	Do you currently have any of the following vision problems?		
	a. Wear contact lenses:	Yes☐	No☐
	b. Wear glasses:	Yes☐	No☐
	c. Color blind:	Yes☐	No☐
	d. Any other eye or vision problem:	Yes☐	No☐
3.	Have you ever had an injury to your ears, including a broken ear drum:	Yes☐	No☐
4.	Do you currently have any of the following hearing problems?		
	a. Difficulty hearing:	Yes☐	No☐
	b. Wearing a hearing aid:	Yes☐	No☐
	c. Any other hearing or ear problem:	Yes☐	No☐
5.	Have you ever had a back injury:	Yes☐	No☐
6.	Do you currently have any of the following musculoskeletal problems?		
	a. Weakness in any of your arms, hands, legs, or feet:	Yes☐	No☐
	b. Back pain:	Yes☐	No☐
	c. Difficulty fully moving your arms and legs:	Yes☐	No☐
	d. Pain or stiffness when you lean forward or backward at the waist:	Yes☐	No☐
	e. Difficulty fully moving your head up or down:	Yes☐	No☐
	f. Difficulty fully moving your head side to side:	Yes☐	No☐
	g. Difficulty bending at your knees:	Yes☐	No☐
	h. Difficulty squatting to the ground:	Yes☐	No☐
	I. Climbing a flight of stairs or a ladder carrying more than 25 lb.:	Yes☐	No☐

Thank you for completing this questionnaire. The clinician will review your answers at the time of your respirator physical. Contingent on your answers and your medical examination, further information about your health and your use of a respirator may be required.