THE UNIVERSITY OF ALABAMA AT BIRMINGHAM
OH&S Occupational Medicine

INITIAL RESPIRATOR USE FORM

Please complete **ALL** of the following information. **Incomplete paperwork will delay processing and approval**.	**DATE:**

Check all that apply: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐ Male ☐ Female

Are you employed by UAB? ☐ Yes ☐ No Are you (circle one): Full Time Part Time Temporary

Last Name		First Name		MI	
Job Title		Work Address			
Date of Birth		Blazer ID		UAB E-Mail	
Department		Work Phone			
Best way to contact you		Alt. Phone			
Supervisor Name					

Age		Height	Ft In	Weight	lbs

Describe your work that requires respirator use (use back of form if more space is required):

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 Respirator Full-Face Respirator Powered-Air Purifying Respirator

Self-Contained Breathing Apparatus

	YES	NO
2. Have you ever worn a respirator?	☐	☐
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)………………………………………………………………………………..	☐	☐
B. Diabetes (sugar disease)…..………………………………………………………………..	☐	☐
C. Allergic reactions that interfere with your breathing……………..…………….……..……	☐	☐
D. Claustrophobia…………..…………………………………………………………..…..….	☐	☐
E. Trouble smelling odors…………..…………………………………………..……….....	☐	☐
5. Have you ever had any of the following pulmonary or lung problems?		
A. Asbestosis………..……………………………………………………….........................	☐	☐
B. Asthma……………………………………………………………………………………..	☐	☐
C. Chronic bronchitis…………………………………………………………………………	☐	☐
D. Emphysema…………………………………………………………………………….	☐	☐
E. Pneumonia……………………………………………………………………………...	☐	☐
F. Tuberculosis…………………………………………………………………………….	☐	☐
G. Silicosis…………………………………………………………………………………	☐	☐
H. Pneumothorax (collapsed lung)………………………………………………...........	☐	☐
I. Lung cancer…………………………………………………………………………….	☐	☐
J. Broken ribs………………………………………………………………………………	☐	☐
K. Any chest injuries or surgeries…………………………………………………………	☐	☐
L. Any other lung problem that you've been told about…………………………………...	☐	☐

	YES	NO
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..………………………..	☐	☐

	YES	NO
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.	☐	☐
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 OHSoccmed@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
3. 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.
4. You may deliver your completed forms to CH19 Suite 412 and place them in the secured lock box at the receptionist desk.