COUNTY OF SACRAMENTO
RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
(MANDATORY *Appendix B-1*)

NOTICE to the Employee: This form is only to be used if you have previously been medically- qualified to use respiratory protective equipment and have an Appendix B form completed after 3/15/12 on file with the County Contracted Clinics. Your Department's Respiratory Protection Program (RPP) Administrator will coordinate the delivery of this follow-up questionnaire to you and will work with the Employee Health Nurse regarding any subsequent follow-up appointment with the Contracted Clinic Physician. Your Supervisor 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, your Supervisor must not look at or review your answers, and must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Licensed Health Care Professional contact information:

Phone Number 916-876-5008 Fax Number 916-874-9252 Inter-Office Mail Code 58-600

SECTION I - MANDATORY To be completed by the Employee (Please Print)		
Name (Last, First):		Employee Number:
Today's Date:	Date of Birth:	Sex: ☐Male ☐Female
Height: ft. in.	Weight: lbs.	Email address:
Contact phone number:		Best time to phone you at this number:
Has your employer told you how to contact the health care professional who will review this questionnaire: (See above for Licensed Health Care Professional contact information)		☐Yes ☐No
Check the type of respirator you will use (you can check more than one category): ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only) ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).		
Have you ever worn a respirator: ☐Yes ☐No If "Yes," what type(s):		

SECTION II - MANDATORY			
Since your last respiratory medical evaluation, have you experienced any of the following:			
Shortness of breath	☐Yes ☐No	Difficult breathing	☐Yes ☐No
Pneumothorax (collapsed lung)	☐Yes ☐No	Recurrent respiratory infection	☐Yes ☐No
Persistent cough	☐Yes ☐No	Wheezing	☐Yes ☐No
Chest pain	☐Yes ☐No	Any chest injuries or surgeries	☐Yes ☐No
Uncontrolled high blood pressure	☐Yes ☐No	Heart attack	☐Yes ☐No
Heart arrhythmia (heart beating irregularly)	☐Yes ☐No	Claustrophobia/anxiety reaction when wearing a respirator	☐Yes ☐No
Have you been hospitalized or been seen by your personal physician for any other medical condition that we should consider?			☐Yes ☐No
If you answered YES to any question(s) in **section IV**, please explain:			

I certify that I have no other medical conditions which will impede my ability to wear a respirator.

Employee's Signature: ____ Date: _______________________