



**YES**      **NO**

- 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.....

**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. | <input type="checkbox"/> | <input type="checkbox"/> |
| A. Have you ever lost vision in either eye (temporarily or permanently)?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Do you currently have any of the following vision problems?  |                          |                          |
| 1. Wear contact lenses.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Wear glasses.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Color blind.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Any other eye or vision problem: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Have you ever had an injury to your ears, including a broken ear drum?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Do you currently have any of the following hearing problems?   |                          |                          |
| 1. Difficulty hearing.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Wear a hearing aid.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Any other hearing or ear problem: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Have you ever had a back injury?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Do you currently have any of the following musculoskeletal problems?   |                          |                          |
| 1. Weakness in any of your arms, hands, legs or feet.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Back pain.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Difficulty fully moving your arms or legs.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Pain or stiffness when you lean forward or backward at the waist.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Difficulty fully moving your head up or down.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Difficulty fully moving your head side to side.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Difficulty bending at your knees.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Difficulty squatting to the ground.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Climbing a flight of stairs or a ladder carrying more than 25 pounds.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Any other muscle or skeletal problem that interferes with using a respirator.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Would you like to talk to the health care professional who will review your answers on this questionnaire?.....   | <input type="checkbox"/> | <input type="checkbox"/> |

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Healthcare 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:**

For Campus employees, you may submit completed forms electronically to [ehsocchealth@uab.edu](mailto:ehsocchealth@uab.edu).

For Highlands, Hospital, HSF and TKC employees, bring form with you to RWUH Suite 117 to be fit tested.