Annual Update Questionnaire All Employee Risk Groups
UTSA OCCUPATIONAL HEALTH PROGRAM

Last Name	First Name	Middle Name	Date of Birth

Department	Supervisor/PI	Job Title

Work Phone	Cell Phone	E-mail

1. Has there been a significant change in your health since you last turned in your Occupational Health Program Questionnaires? Describe:	YES ☐	NO ☐
2. Have you had a body weight increase or decrease of 10% or more in the last year? Describe:	YES ☐	NO ☐
3. Have you had any animal related WORK injuries during the past year? If yes, explain. Skin (eczema, allergies): Respiratory (allergies, asthma):	YES ☐	NO ☐
4. During the past year, have you had a work related injury or illness that you have not reported to your supervisor? If yes, explain.	YES ☐	NO ☐
5. Has your exposure to hazards changed? If yes, explain. Describe:	YES ☐	NO ☐

NOTE: Bloodborne Pathogen Training: (*SA456* - ***Non Researchers*** or *SA483* - ***Researchers***) is required annually for all personnel who work with human blood or blood products or human tissues, fluids, or cells that are considered "other potentially infectious materials" (OPIM).

Have you completed your annual BBP training? ◯ Yes ◯ No

If there are no significant changes in your animal contact or hazard exposure, a visit with the occupational health nurse may not be indicated. However, if you have questions or concerns, please e-mail us at UTSAohp@utsa.edu.

Signature_____ Date_____

Nurse Reviewer_____ Date_____

Annual Respiratory Protection Survey
UTSA OCCUPATIONAL HEALTH PROGRAM

Last Name	First Name	Middle Name	Date of Birth

Department	Supervisor/PI	Job Title

Work Phone	Cell Phone	E-mail

Gender ☐ Male ☐ Female Height ____ ft.____ in. Weight _____ lbs.

_____ I am not required and/or do not wear a respirator while working in the lab. However, if I do start using a respirator I will notify the UTSA Occupational Health Program and will update my paperwork. Also, I understand that I may have to complete a Respiratory Questionnaire, Respiratory Physical and/or Respiratory Fit Test.

** *OR* **

The following information must be provided by every employee who has been selected to use any type of respirator.
Type of respirator you will use (you can check more than one category)

Filter-mask, non-cartridge type only

☐ N95/100
☐ R95/100
☐ P95/100

OTHER:

☐ Air-purifying (powered) (PAPR)
☐ ½ Face with Cartridge
☐ Full Face with Cartridge
☐ Supplied Air Respirator (SCBA)

Make _____ Model _____ Cartridge _____

Please circle yes or no

Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month?	YES	NO
Have you had any pulmonary or lung problems since your last fit test?	YES	NO
Have you had any cardiovascular or heart problems since your last fit test?	YES	NO
Have you had a body weight increase **or** decrease of 10% or more in the last year? Describe:	YES	NO
Have you had a significant change in your facial structure that would compromise the fit of respiratory protection? (Facial surgery, scarring, dental work) Describe:	YES	NO
Have your duties or exposure while wearing respiratory protection changed significantly since your last fit test? (Different pathogens, contaminants, exertion levels, ambient temperatures) Describe:	YES	NO

Signature _____ Date _____

Nurse Reviewer _____ Date _____

Return Forms via Campus Mail to EHSRM/Occupational Health Coordinator or Fax to 5072