Occupational Health Services
MICHIGAN MEDICINE
C380 Med Inn Building; 5838
Phone: (734) 764-8021

Respirator Medical Evaluation Questionnaire
University of Michigan Employee

Appendix C to Sec. 1910.134:
OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
To the employee: *Your employer 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 employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.*

Part A. Section 1. *(Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).*

Name: _____ Date: _____

E-mail address: _____ Job Title: _____

Dept: _____ Supervisor/PI Name: _____

Phone # _____ The best time to reach you at this number: _____

***(where you can be reached by the health care professional who reviews this questionnaire)*:**

Date of Birth_____ Age (to the nearest year): _____ Gender: Male/ Female (circle one)

UMID #_____ Height:_____ ft _____in Weight: _____ lbs.

1. Has your employer told you how to contact the health care professional who will review this questionnaire?
   ○Yes ○No

Complete all 3 pages and bring with you to OHS

2. Check the type of respirator you will use (you can check more than one category):

   ☐Disposable respirator (filter-mask, non-cartridge type only i.e., N95)
   ☐Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus SCBA)

3. Are you currently using a respirator? ○Yes ○No

   What type(s) _____

If PAPR (Hospital employees only) ... Training/Fit Test done at OHS

Part A. Section 2. *(Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please indicate ``yes'' or ``no'').*

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 (fits) ○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

If "yes," name the medications if you know them: _____

_____

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9) ☐

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

9. Would you like to talk to the health care professional that will review this questionnaire about your answers to this questionnaire? ○ Yes ○ No

10. Have you *ever lost* vision in either eye (temporarily or permanently)? ○ Yes ○ No

11. 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

12. Have you *ever had* an injury to your ears, including a broken eardrum? ○ Yes ○ No

13. Do you *currently* have any of the following hearing problems?
    a) Difficulty hearing ○ Yes ○ No
    b) Wear a hearing aid ○ Yes ○ No
    c) Any other hearing or ear problem ○ Yes ○ No

14. Have you *ever had* a back injury? ○ Yes ○ No

15. 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 lbs. ○ Yes ○ No
    j) Any other muscle or skeletal problem that interferes with using a respirator ○ Yes ○ No

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ASSESSMENT – TO BE COMPLETED BY AN OCCUPATIONAL HEALTH SERVICES PROVIDER

- ◉ **Employee is cleared to perform job duties with use of a respirator**
- ○ **Employee notified to contact Occupational Health Service for further evaluation** _____
- ○ **Other recommendations:** _____

It should be noted that medical qualification for respirator use is dependent upon proper fit testing and instruction regarding use and maintenance of respiratory equipment.

_____ _____

Reviewers' signature **Date**