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Hospital Employees
Please bring completed form
with you to OHS for fit testing

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? (circle one) Yes/ No

Complete all 3 pages and bring to U-M Occupational Health Clinic for fit testing

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? (circle one) Yes/ No

What type(s) _____

If Breathe Easy 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

- 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

Name: _____

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

Name: _____

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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

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