APPENDIX D Respirator Medical Evaluation

This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to safely wear a respirator. We anticipate being able to approve most people for respirator use based on this questionnaire alone. In some cases we may ask for more information or additional medical testing/evaluation. Fit testing is also required and is done separately. All medical information is considered confidential.

All Information Must Be Completed For Respirator Approval

Name:	**Age:**	**M #**
Department:	**Work Phone:**	**Today's Date**

1) When using a respirator, work is: a) ☐ Light b) ☐ Moderate c) ☐ Heavy	**2) Shifts per week respirator is worn:** a) ☐ Less than 1 b) ☐ 1-4 c) ☐ Almost every shift	**Length of time respirator is worn during shift:** a) ☐ Less than 1 hour b) ☐ 1-5 hours c) ☐ 5-12 hours

Medical History

Has a doctor ever told you that you had the following ?

	Yes	No		Yes	No
1. Angina			7. Lung Disease		
2. Heart Attack			8. Emphysema		
3. Heart Disease			9. Asthma		
4. Epilepsy or Seizures			10. Are you allergic to natural latex?		
5. High Blood Pressure			11. Smoking History a) ☐ Smoker		
6. Diabetes treated with insulin			b) ☐ Ex-Smoker c) ☐ Never Smoked		

Explain "yes" answers by number

12. Are you currently taking any medications? Please list

Review of Systems

	Yes	No
13. Are you short of breath at rest?		
14. Do you get short of breath when walking ?		
15. Do you get short of breath at work?		
16. Do you get chest pain with certain activities?		
17. Do you get chest pain at work?		
18. Do you have medical problems that might interfere with respirator use?		
19. Have you ever had problems wearing a respirator?		

20. Current level of activity/exercise Work/ ☐ Sedentary ☐ Non-Sedentary
Do you exercise ? ☐ Yes ☐ No How Often ?

Explain "yes" answers by number

Employee Signature **Date:**

Medical Department Use Only

☐ Approved ☐ Approved With Restrictions ☐ Denied ☐ More Information Needed (Specify)

Restrictions Remarks

Physicians Signature **Date:**

To the Employer:

Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the Employee:

Can you read ☐ **yes** ☐ **no**

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 you seal this form and mail it directly to the address below. DO NOT FAX. Call University Health Services at (513) 584-4457 to reach the health care professional who will review this form if you have any questions.

University Health Services

ML 0460

1st floor Holmes Hospital

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

- Are you a UC student? ☐ **yes** ☐ **no**

1. Your name: _____ Employee ID#_____
2. Today's date: _____ DOB _____
3. Your age (to nearest year): _____
4. Gender (circle one) **Male** **Female**
5. Your height:_____ft. _____in.
6. Your weight:_____lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):_____
9. The best time to phone you at this number:_____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (include the Area Code): _____
11. Check the type of Respirator you will use (you can check more than one category):
    a. _____N, R, or P disposable respirator (filter mask, non-cartridge type only).
    b. _____Other type (for example, half- of full-facepiece type, powered–air purifying, supplied-air, self-contained breathing apparatus)
12. Have you worn a respirator before?
13. If "yes" what type(s) (not brand name)_____

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

1. ☐ **yes** ☐ **no** Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month?

2. Have you ***ever had*** any of the following conditions?

a. ☐ **yes** ☐ **no** Seizures (fits)

b. ☐ **yes** ☐ **no** Diabetes (sugar disease)

c. ☐ **yes** ☐ **no** Allergic reactions that interfere with your breathing

d. ☐ **yes** ☐ **no** Claustrophobia (fear of closed-in places)

e. ☐ **yes** ☐ **no** Trouble smelling odors

3. Have you ***ever had*** any of the following pulmonary or lung problems?

a. ☐ **yes** ☐ **no** Asbestosis

b. ☐ **yes** ☐ **no** Asthma

c. ☐ **yes** ☐ **no** Chronic bronchitis

d. ☐ **yes** ☐ **no** Emphysema

e. ☐ **yes** ☐ **no** Pneumonia

f. ☐ **yes** ☐ **no** Tuberculosis

g. ☐ **yes** ☐ **no** Silicosis

h. ☐ **yes** ☐ **no** Pneumothorax (collapsed lung)

i. ☐ **yes** ☐ **no** Lung cancer

j. ☐ **yes** ☐ **no** Broken ribs

k. ☐ **yes** ☐ **no** Any chest injuries or surgeries

l. ☐ **yes** ☐ **no** Any other lung problem that you've been told about

4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?

a. ☐ **yes** ☐ **no** Shortness of breath

b. ☐ **yes** ☐ **no** Shortness of breath when walking fast on level ground or walking up a slight hill or incline

c. ☐ **yes** ☐ **no** Shortness of breath when walking with other people at an ordinary pace on level ground

d. ☐ **yes** ☐ **no** Have to stop for breath when walking at your own pace on level ground

e. ☐ **yes** ☐ **no** Shortness of breath when washing or dressing yourself

f. ☐ **yes** ☐ **no** Shortness of breath that interferes with your job

g. ☐ **yes** ☐ **no** Coughing that produces phlegm (thick sputum)

h. ☐ **yes** ☐ **no** Coughing that wakes you early in the morning

i. ☐ **yes** ☐ **no** Coughing that occurs mostly when you are lying down

j. ☐ **yes** ☐ **no** Coughing up blood in the last month

k. ☐ **yes** ☐ **no** Wheezing

l. ☐ **yes** ☐ **no** Wheezing that interferes with your job

m. ☐ **yes** ☐ **no** Chest pain when you breathe deeply

n. ☐ **yes** ☐ **no** Any other symptoms that you think may be related to lung problems

5. Have you ***ever had*** any of the following cardiovascular or heart problems?

a. ☐ **yes** ☐ **no** Heart attack

b. ☐ **yes** ☐ **no** Stroke

c. ☐ **yes** ☐ **no** Angina

d. ☐ **yes** ☐ **no** Heart failure

e. ☐ **yes** ☐ **no** Swelling in your legs or feet (not caused by walking)

f. ☐ **yes** ☐ **no** Heart arrhythmia (heart beating irregularly)

g. ☐ **yes** ☐ **no** High blood pressure

h. ☐ **yes** ☐ **no** Any other heart problem that you've been told about

6. Have you ***ever had*** any of the following cardiovascular or heart symptoms?

a. ☐ **yes** ☐ **no** Frequent pain or tightness in your chest during physical activity

b ☐ **yes** ☐ **no** Pain or tightness in your chest during physical activity

c. ☐ **yes** ☐ **no** Pain or tightness in your chest that interferes with your job

d. ☐ **yes** ☐ **no** In the past two years, have you noticed your heart skipping or missing a beat

e. ☐ **yes** ☐ **no** Heartburn or indigestion that is not related to eating

f. ☐ **yes** ☐ **no** Any other symptoms that you think may be related to heart of circulation problems

7. Do you ***currently*** take medication for any of the following problems?

a. ☐ **yes** ☐ **no** Breathing or lung problems

b. ☐ **yes** ☐ **no** Heart trouble

c. ☐ **yes** ☐ **no** Blood pressure

d. ☐ **yes** ☐ **no** Seizures (fits)

8. If you've used a respirator, have you ever had any of the following problems?

(If you've never used a respirator, check here ☐ and go to question 9)

a. ☐ **yes** ☐ **no** Eye irritation

b. ☐ **yes** ☐ **no** Skin allergies or rashes

c. ☐ **yes** ☐ **no** Anxiety

d. ☐ **yes** ☐ **no** General weakness or fatigue

e. ☐ **yes** ☐ **no** Any other problem that interferes with your use of a respirator

9. ***Would you like*** to speak with the health care professional who will review this questionnaire about your answers to this questionnaire? ☐ **yes** ☐ **no**

Questions 10 to 15 below must be answered **by every employee who has been selected to use either**

- **A full-facepiece respirator** *or*
- **Self contained breathing apparatus (SCBA).**

For employees who have been selected to use other types of respirators, answering these questions is voluntary

10. ☐ **yes** ☐ **no** ***Have you ever lost*** vision in either eye (temporarily or permanently)

11. ***Do you currently have*** any of the following vision problems?

a. ☐ **yes** ☐ **no** Wear contact lenses:

b. ☐ **yes** ☐ **no** Wear glasses:

c. ☐ **yes** ☐ **no** Color blind:

d. ☐ **yes** ☐ **no** Any other eye or vision problem

12. ☐ **yes** ☐ **no** ***Have you ever had*** an injury to your ears, including a broken ear drum?

13. Do you ***currently*** have any of the following musculoskeletal problems?

a. ☐ **yes** ☐ **no** Difficulty hearing:

b. ☐ **yes** ☐ **no** Wear a hearing aid:

c. ☐ **yes** ☐ **no** Any other hearing or ear problem

14. ☐ **yes** ☐ **no** ***Have you ever had*** a back injury?

15. ***Do you currently have*** any of the following musculoskeletal problems?

a. ☐ **yes** ☐ **no** Weakness in any of your arms, hands, legs, or feet:

b. ☐ **yes** ☐ **no** Back pain:

c. ☐ **yes** ☐ **no** Difficulty fully moving your arms and legs:

d. ☐ **yes** ☐ **no** Pain or stiffness when you lean forward or backward at the waist:

e. ☐ **yes** ☐ **no** Difficulty fully moving your head up or down:

f. ☐ **yes** ☐ **no** Difficulty fully moving your head side to side:

g. ☐ **yes** ☐ **no** Difficulty bending at your knees:

h. ☐ **yes** ☐ **no** Difficulty squatting to the ground:

i. ☐ **yes** ☐ **no** Climbing a flight of stairs or a ladder carrying more than 25 lbs:

j. ☐ **yes** ☐ **no** Any other muscle or skeletal problem that interferes with using a respirator: