UNIVERSITY OF MARYLAND
UNIVERSITY HEALTH CENTER
Respirator Medical Evaluation Questionnaire

Please complete parts A and B. Incomplete forms will be returned

KFS# (Required from department): ____________________________

Part A.

Section I: The following information must be provided by every employee who has been selected to use any type of respirator

Name:                      Date:            UID:            Age:            Gender:
Height:             Weight:          Job Title:             Department:
Preferred Contact #:         Supervisor:

Email:

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

☐  N, R, or P disposable respirator (filter-mask, non-cartridge type only)
☐  Other type (for example, half-or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator?  ☐ Yes  ☐ No If yes, what type?

Respirator is used to protect you from what agent(s):

☐  CS/CN, Pepper Spray and hazardous materials (Police Only)
☐  Other: ____________________________

How much does your respirator weigh?:

☐  <2.5 lbs
☐  2.5 - 5 lbs
☐  5 - 10 lbs
☐  Other ____________________________

Section II: 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. 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 illnesses?
   a. Shortness of breath
   b. Shortness of breath when walking fast on level ground or walking 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

5. 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 (not caused by walking)
   f. Heart arrhythmia (heart beating irregularly)
   g. High blood pressure
   h. Any other heart problem that you’ve been told about

6. 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

7. 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)

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
   b. Skin allergies or rashes
   c. Anxiety
   d. General weakness or fatigue
   e. Any other problem that interferes with your use of a respirator

9. Would you like to talk to the health care professional who will review this questionnaire about
   your answers to this questionnaire?

   ☐ Yes  ☐ No
Questions 10 - 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

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
   - b. Wear glasses
   - c. Color blind
   - d. Any other eye or vision problems

12. Have you ever had an injury to your ears, including a broken ear drum?
   - Yes
   - No

13. Do you currently have any of the following hearing problems?
   - a. Difficulty hearing
   - b. Wear a hearing aid
   - c. Any other hearing or ear problem

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
   - b. Back pain
   - c. Difficulty fully moving your arms and legs
   - d. Pain or stiffness when you lean forward or backward at the waist
   - e. Difficulty fully moving your head up or down
   - f. Difficulty fully moving your head side to side
   - g. Difficulty bending at your knees
   - h. Difficulty squatting to the ground
   - i. Climbing a flight of stairs or a ladder carrying more than 25 lbs:
   - j. Any other muscle or skeletal problem that interferes with using a respirator
**Part B.**

**All respirator users, please answer these additional questions:**

1. How often are you expected to use to use the respirator(s)? Check all that apply to you:
   - [ ] Escape Only (no rescue)
   - [ ] Emergency rescue only
   - [ ] Less than 5 hours per week
   - [ ] Less than 2 hours per day
   - [ ] 2 to 4 hours per day
   - [ ] Over 4 hours per day

2. During the period you are using the respirator(s), is your work effort:
   - [ ] Light (less than 200 kcal per hour)
     If yes, how long does this period last during the average shift? _____ hrs. _____ mins.
     **Examples of light work effort are:**
     - Sitting while writing, typing, drafting, or performing light assembly work;
     - Standing while operating a drill press (1-3lbs) or controlling machines.
   - [ ] Moderate (200-350 kcal per hour)
     If yes, how long does this period last during the average shift? _____ hrs. _____ mins.
     **Examples of moderate work effort are:**
     - Sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, filing, or performing assembly work. or transferring a moderate load (about 35lbs) at trunk level;
     - Walking on a level surface about 2mph or down a 5-degree grade about 3 mph; pushing a wheelbarrow with heavy load (about 100lbs on a level surface)
   - [ ] Heavy (over 350 kcal per hour)
     If yes, how long does this period last during the average shift? _____ hrs. _____ mins.
     **Examples of heavy work effort are:**
     - Lifting a heavy load (about 50lbs) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2mph; climbing stairs with a heavy load (about 50lbs)

3. Will you be wearing protective clothing and/or equipment (other than the respirator) while you are using your respirator?
   - [ ] Yes  [ ] No
   If yes, describe clothing/equipment: ____________________________________________________________

4. Will you be working under hot conditions (temp. exceeding 77 degrees F)?
   - [ ] Yes  [ ] No

5. Will you be working under humid conditions?
   - [ ] Yes  [ ] No

6. Describe the work you will be doing while you are using your respirator(s):
   ______________________________________________________________________________________

7. Describe any special or hazardous conditions you might encounter when you are using your respirator(s):
   ______________________________________________________________________________________

Signature: _______________________________  Date: ___________________
With your completed form, please send a signed copy of the University Health Center Notice of Privacy Practice.

Please send completed and signed questionnaire to:

Occupational Health/University Health Center
Bldg 140, Campus Drive, Room 0106
College Park, MD 20742

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I acknowledge that I have received a copy of the University of Maryland Health Center's Notice of Privacy Practices.

Printed Name ___________________________ Signature ___________________________ Date ________________

FOR INTERNAL USE ONLY

☐ Patient refused to provide signature for acknowledging receipt of privacy practices.

_________________________________________.

UHC Staff signature or designee and date.

☐ Patient was incapacitated and unable to provide signature for acknowledging receipt of privacy practices.

_________________________________________.

UHC Staff signature of designee and date