

Cleared 1 or 2  
 Not Cleared  
 Cleared w/ Restrictions  
 Provider Initials  
 Date

# 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.

<b>Section I:</b> The following information must be provided by every employee who has been selected to use any type of respirator					
<b>Name:</b>		<b>Date:</b>	<b>UID:</b>	<b>Age:</b>	<b>Gender:</b>
<b>Height:</b>	<b>Weight:</b>	<b>Job Title:</b>		<b>Department:</b>	
<b>Preferred Contact # :</b>			<b>Supervisor:</b>		
<b>Email:</b>					
<b>Check the type of respirator you will use (you can check more than one category):</b>					
<input type="checkbox"/> N, R, or P disposable respirator (filter-mask, non-cartridge type only)					
<input type="checkbox"/> Other type (for example, half-or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).					
<b>Have you worn a respirator?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>If yes, what type?</b>		
<b>Respirator is used to protect you from what agent(s):</b>			<b>How much does your respirator weigh?:</b>		
<input type="checkbox"/> CS/CN, Pepper Spray and hazardous materials (Police Only)			<input type="checkbox"/> <2.5 lbs		
<input type="checkbox"/> Other: _____			<input type="checkbox"/> 2.5 - 5 lbs		
			<input type="checkbox"/> 5 - 10 lbs		
			<input type="checkbox"/> Other _____		

<b>Section II:</b> Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. Please check <b>yes</b> or <b>no</b> .	
<b>1. Do you currently smoke tobacco, or have you smoked tobacco in the last month:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2. Have you ever had any of the following conditions?</b>	
a. Seizures (fits)	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Diabetes (sugar disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Allergic reactions that interfere with your breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Claustrophobia (fear of closed-in places)	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Trouble smelling odors	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3. Have you ever had any of the following pulmonary or lung problems?</b>	
a. Asbestosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Chronic bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Silicosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Pneumothorax (collapsed lung)	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Lung cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Broken ribs	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Any chest injuries or surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Any other lung problem that you've been told about	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| a. Shortness of breath  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Shortness of breath when walking with other people at an ordinary pace on level ground       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Have to stop for breath when walking at your own pace on level ground                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Shortness of breath when washing or dressing yourself  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Shortness of breath that interferes with your job  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Coughing that produces phlegm (thick sputum)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Coughing that wakes you early in the morning   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Coughing that occurs mostly when you are lying down  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Coughing up blood in the last month  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Wheezing   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Wheezing that interferes with your job   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m. Chest pain when you breathe deeply   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| n. Any other symptoms that you think may be related to lung problems                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Heart attack  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Stroke  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Angina  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Heart failure   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Swelling in your legs or feet (not caused by walking) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Heart arrhythmia (heart beating irregularly)          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. High blood pressure                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Any other heart problem that you've been told about   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Frequent pain or tightness in your chest  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Pain or tightness in your chest during physical activity                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Pain or tightness in your chest that interferes with your job                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. In the past two years, have you noticed your heart skipping or missing a beat     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Heartburn or indigestion that is not related to eating                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Any other symptoms that you think may be related to heart or circulation problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

- |                               |                              |                             |
|-------------------------------|------------------------------|-----------------------------|
| a. Breathing or lung problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Heart Trouble              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Blood Pressure             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Seizures (fits)            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**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  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Skin allergies or rashes  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Anxiety   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. General weakness or fatigue                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Any other problem that interferes with your use of a respirator | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> 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              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Wear glasses                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Color blind                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Any other eye or vision problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**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               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Wear a hearing aid               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Any other hearing or ear problem | <input type="checkbox"/> Yes | <input type="checkbox"/> 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                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Back pain  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Difficulty fully moving your arms and legs                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Pain or stiffness when you lean forward or backward at the waist             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Difficulty fully moving your head up or down                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Difficulty fully moving your head side to side                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Difficulty bending at your knees   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Difficulty squatting to the ground   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Climbing a flight of stairs or a ladder carrying more than 25 lbs:           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Any other muscle or skeletal problem that interferes with using a respirator | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

*Please continue to **Part B** on the next page*

# 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: \_\_\_\_\_



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Printed Name Signature Date

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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