University of Maryland Medical Center
Medical Clearance for Respiratory Protection Questionnaire

Today's Date:________________

Employee Name: ____
Home Address: ____
City, State, Zip: ____
Home Phone: ____
Work Phone: ____

SSN: _____/______/_____ DOB: _____/_____/____

Job Title: _________________________Department:_________________________

Are you required to wear a respirator for your job? ☒Yes ❒ No

Note: If you are required to be fitted and ready to wear respiratory equipment, you must answer the following questions as required by the new OSHA Respiratory Protection standard. For your convenience, some questions have been answered for you, but you may change the answer.

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).

1. The type of respirator you will use shall be an N95 Respirator or PAPR

2. Have you worn a respirator (circle one)?: Yes No

If "yes," what type(s):____

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 circle "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month:

Yes No

If yes, and you want more information on how to quit smoking, please call Employee Health Service at 8-8632.

2. Have you <u>ever</u> had any of the following conditions?

a. Current seizures (fits):	Yes	No
b. Uncontrolled diabetes (sugar disease):	Yes	No
c. Allergic reactions that interfere with your breathing:	Yes	No
d. Claustrophobia (fear of closed-in places) that might interfere with using a respirator:	Yes	No
e. Trouble smelling odors:	Yes	No

3. Have you <u>ever</u> had any of the following pulmonary or lung problems?

a. Asbestosis:	Yes	No
b. Asthma:	Yes	No
c. Chronic bronchitis (i.e., ongoing cough or phlegm over several months):	Yes	No
d. Emphysema:	Yes	No
e. Current or frequent 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 in past year or still causing pain:	Yes	No
k. Any chest injuries/ surgeries in past year or still causing pain or breathing problems:	Yes	No
l. Any other long-term or current lung problem 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. Very short of breath when walking fast on level ground or walking up a slight hill or incline:	Yes	No
c. Very short 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. Cough 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. Do you currently have any of the following cardiovascular or heart problems?

a. Heart attack in past year or current symptoms:	Yes	No
b. Stroke in past year or current symptoms:	Yes	No
c. Current angina:	Yes	No
d. Heart failure:	Yes	No
e. Current swelling in your legs or feet (not caused by walking):	Yes	No
f. Heart arrhythmia (heart beating irregularly):	Yes	No
g. Uncontrolled high blood pressure (>140/90):	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
e. Do you have any side effects of any medication that might affect your ability to use a respirator?:	Yes	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:	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 who will review this questionnaire about your answers to this questionnaire?: Yes No

10. **Apart from patient care, describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well being of others?**:

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The information supplied in this questionnaire is true to the best of my knowledge.

______________________ ______________

Employee Signature Date

Reviewing Health Care Professional Comments:

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Reviewing Health Care Professional Comments:

- ☐ **Medically Fit- No medical condition that would place the employee at increased risk to wear respiratory protection**
- ☐ **Fitness Determination Pending -______________________**
- ☐ **Medically Fit with the following restrictions:______________________**
- ☐ **Not Medically Fit: Reason______________________**

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______________________ ______________________ ______________

Signature of Health Care Professional Printed Name Date

OSHA resp questionnaire 03/31/09