THE UNIVERSITY OF TOLEDO MEDICAL CENTER

UNIVERSITY OF TOLEDO

Respirator Medical Evaluation Questionnaire

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			Job Title	Date
Weight	Age	Height	Sex (circle one) Male Female	
Main Campus ☐		Scott Park ☐		Health Science Campus ☐
1. Can you read (circle one) Yes No				
2. Phone number where you can be reached by the health care professional who reviews this questionnaire.				
3. Best time to reach you at the above phone number.				
4. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one) Yes/No				
5. 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- or full-face-piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).				
6. 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 check "yes" or "no").	**Yes**	**No**
1. 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. Seizures (fits)		
b. Diabetes (sugar disease)		
c. Allergic reactions that interfere with your breathing		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling odors		
3. Have you **ever had** any of the following pulmonary or lung problems?		
a. Asbestosis		
b. Asthma		
c. Chronic bronchitis		
d. Emphysema		
e. Pneumonia		

Part A Section 2 (Continue)	Yes	No
f. Tuberculosis		
g. Silicosis		
h. Pneumothorax (collapsed lung)		
i. Lung Cancer		
j. Broken ribs		
k. Any chest injuries or surgeries		
l. 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. 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 problems 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		

Part A Section 2 (Continue)	**Yes**	**No**
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?		

Medical Clearance for Respirator Use/Fit Test Record

Name	Date of Birth	SS#
Department	**Job Title**	**Daytime Phone #**

Type of respirator(s) to be used by the employee:

x Air-Purifying (N-95 Disposable)
☐ Air-Purifying (PAPR)
☐ Air-Purifying (Half/Full Face)
☐ SCBA
☐ Other

Select level of work effort

☐ Light
x Moderate
☐ Heavy/Strenuous

Extent of usage

☐ On a daily basis
☐ Occasionally, but more than once a week
☐ Rarely, or for emergency situations only

Length of time of anticipated effort (hours):

Special work considerations (i.e., high places, temperature, hazardous materials, protective clothing, etc.

A Licensed Health Care Professional (LHCP) will review questions 1-9 in Part A, Section 2. If an employee marks NO to all 9 questions, the LHCP will mark the box indicating "No restrictions on respirator use". If an employee marks yes to any of the first 9 questions, the LHCP will forward to a physician for review by marking the box indicating "Follow-up medical evaluation needed."

CLEARANCE (CHECK ONE)

No restrictions on respirator use	❑	Follow-up medical evaluation needed	❑

Reviewing Nurse: _____ (Signature)

The reviewing physician will determine the employee's ability to wear a respirator. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

FOLLOW UP MEDICAL EVALUATION (CHECK ONE)

Respirator use not Permitted	❑	Respirator use with restrictions	❑
No restrictions on respirator use	❑		

Noted Restrictions:

Examining Physician: _____ (Signature)

FIT TEST ***(circle one)***

Respirator Selected	Size	Fit Test Method
3M 1860S	Small	Bitrex
3M 9210		Saccharin
Other		Port-A-Count

Sensitivity Test ❑ Pass ❑ Fail **Fit Test** ❑ Pass ❑ Fail

Employee Signature: _____ Date: _____

Test Conductor Signature: _____ Date: _____

Please Return Completed RPP Questionnaire To:

Student Health and Wellness Center
Ruppert Health Center Suite 0013
or Fax to 419-383-6251

Family Medicine Center
Ruppert Health Center, Suite M
Fax: 419-383-3113