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:	<i>l</i> l	_
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, y questions as required by the new OSHA Respiratory Protection standard. For yo have been answered for you, but you may change the answer.		
who has been selected to use any type of respirator (please print).	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		
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If "yes," what type(s):	Yes Very employed Health Service Yes Yes Yes Yes	e at 8-8632. No No 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 (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
1. Any other long-term or current lung problem you've been told about:	Yes	No

4. Do you <u>currently</u> 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	Yes	No
incline:		
c. Very short of breath when walking with other people at an ordinary pace on level	Yes	No
ground:		
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
1. 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 <u>currently</u> 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 v	you	currently	take	medication	for an	y of the	following	problems	?
٠.	D U :	you	currently	unix	medication	ioi an	y or the	10110 111116	, problems	•

b. Heart trouble: c. Blood pressure: d. Seizures (fits): e. Do you have any side effects of any medication that might affect your ability to use a respirator?: No No No No No No No No No N	c. Blood pressure: d. Seizures (fits): e. Do you have any side effects of any medication that might affect your ability to use a Yes No	c. Blood pressure: d. Seizures (fits): e. Do you have any side effects of any medication that might affect your ability to use a respirator?:	Yes Yes	No
d. Seizures (fits): e. Do you have any side effects of any medication that might affect your ability to use a respirator?: No No	d. Seizures (fits): e. Do you have any side effects of any medication that might affect your ability to use a respirator?: No respirator?: 8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator):	d. Seizures (fits): e. Do you have any side effects of any medication that might affect your ability to use a respirator?:	Yes	
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respirator?:	8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a res	respirator?:	37	
			Yes	No

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

-	om patient care, describe any spo te safety and well being of other	ecial responsibilities you'll have whi s?:	lle using your respirator(s) that
The informati	on supplied in this questionnaire i	s true to the best of my knowledge.	
Employee Sig	gnature	Date	
Reviewing Ho	ealth Care Professional Comments	:	
Reviewing He	ealth Care Professional Comments	:	
	Medically Fit- No medical o	condition that would place the e	mployee at increased
	Fitness Determination Pen	ding	
		wing restrictions:	
	Health Care Professional Printed		 Date

OSHA resp questionnaire 03/31/09