Eastern Michigan University
Respirator Medical Evaluation

This questionnaire aids in determining if you have a medical condition that may affect your ability to safely wear a respirator. In some cases, additional information, an in person consultation with the medical staff and/or medical testing may be needed. All medical information is confidential.

ALL MANDATORY INFORMATION MUST BE COMPLETED

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. Today's date:			
2. Your name:			
3. Your age (to nearest year):			
4. Sex (circle one):		Male	Female
5. Your height:		ft.	in.
6. Your weight:		lbs.	
7. Your job title:			
8. A phone number where you can be reached by the health care professional Who reviews this questionnaire (including the Area Code):			
9. The best time to phone you at this number:			
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one):		Yes	No
11. 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-facepiece type, powered-air purifying, supplied-air, self- contained breathing apparatus).	
12. 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
2. Have you ever had any of the following conditions?			
a.	Seizures:	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 illness?			
a.	Shortness of breath:	Yes	No
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	Yes	No
c.	Shortness 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.	Coughing 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. Have you ever had any of the following cardiovascular or heart problems?			
a.	Heart attack:	Yes	No
b.	Stroke:	Yes	No
c.	Angina:	Yes	No
d.	Heart failure:	Yes	No
e.	Swelling in your legs or feet (not caused by walking):	Yes	No
f.	Heart arrhythmia (heart beating irregularly):	Yes	No
g.	High blood pressure:	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:	Yes	No
8. If you have used a respirator, have you ever had any of the following problems? (If you have 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
Questions 10 to 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:	Yes	No
b.	Wear glasses:	Yes	No
c.	Color blind:	Yes	No
d.	Any other eye or vision problem:	Yes	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:	Yes	No
b.	Wear a hearing aid:	Yes	No
c.	Any other hearing or ear problem:	Yes	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:	Yes	No
b.	Back pain:	Yes	No
c.	Difficulty fully moving your arms and legs:	Yes	No
d.	Pain or stiffness when you lean forward or backward at the waist:	Yes	No
e.	Difficulty fully moving your head up or down:	Yes	No
f.	Difficulty fully moving your head side to side:	Yes	No
g.	Difficulty bending at your knees:	Yes	No
h.	Difficulty squatting to the ground:	Yes	No
i.	Climbing a flight of stairs or a ladder carrying more than 25 lbs.:	Yes	No
j.	Any other muscle or skeletal problem that interferes with using a respirator:	Yes	No
Part B. Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.			
1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen:		Yes	No
	If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions:	Yes	No
2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals:		Yes	No
	If "yes," name the chemicals if you know them:		
3. Have you ever worked with any of the materials, or under any of the conditions, listed below:			
a.	Asbestos:	Yes	No
b.	Silica (e.g., in sandblasting):	Yes	No
c.	Tungsten/cobalt (e.g., grinding or welding this material):	Yes	No
d.	Beryllium:	Yes	No
e.	Aluminum:	Yes	No
f.	Coal (for example, mining):	Yes	No
g.	Iron:	Yes	No
h.	Tin:	Yes	No
i.	Dusty environments:	Yes	No
j.	Any other hazardous exposures:	Yes	No
	If "yes," describe these exposures:		
4. List any second jobs or side businesses you have:			

5. List your previous occupations:			
6. List your current and previous hobbies:			
7. Have you been in the military service?		Yes	No
	If "yes," were you exposed to biological or chemical agents (either in training or combat):	Yes	No
8. Have you ever worked on a HAZMAT team?		Yes	No
9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications):		Yes	No
	If "yes," name the medications if you know them		
10. Will you be using any of the following items with your respirator(s)?			
a.	HEPA Filters:	Yes	No
b.	Canisters (for example, gas masks):	Yes	No
c.	Cartridges:	Yes	No
11. How often are you expected to use the respirator(s)? (circle "yes" or "no" for all answers that apply to you):			
a.	Escape only (no rescue):	Yes	No
b.	Emergency rescue only:	Yes	No
c.	Less than 5 hours per week:	Yes	No
d.	Less than 2 hours per day:	Yes	No
e.	2 to 4 hours per day:	Yes	No
f.	Over 4 hours per day:	Yes	No
12. During the period you are using the respirator(s), is your work effort:			
a.	Light (less than 200 kcal per hour):	Yes	No
	If "yes," how long does this period last during the average shift:	hrs	mins
	Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.		
b.	Moderate (200 to 350 kcal per hour):	Yes	No
	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, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.		
c.	Heavy (above 350 kcal per hour):	Yes	No
	If "yes," how long does this period last during the average shift:	hrs	mins
	Examples of heavy work are lifting a heavy load (about 50 lbs.) 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 2 mph; climbing stairs with a heavy load (about 50 lbs.).		
13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator:		Yes	No
	If "yes," describe this protective clothing and/or equipment:		
14. Will you be working under hot conditions (temperature exceeding 77 deg. F):		Yes	No
15. Will you be working under humid conditions:		Yes	No
16. Describe the work you'll be doing while you're using your respirator(s):			

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):		
18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s)		
	Name of the first toxic substance:	
		Estimated maximum exposure level per shift:
		Duration of exposure per shift:
	Name of the second toxic substance:	
		Estimated maximum exposure level per shift:
		Duration of exposure per shift:
	Name of the third toxic substance:	
		Estimated maximum exposure level per shift:
		Duration of exposure per shift:
	The name of any other toxic substances that you'll be exposed to while using your respirator:	
19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):		

The EMU Respirator Medical Evaluation was developed from the Department of Licensing and Regulatory Affairs MIOSHA Occupational Health Standard Part 451. Respiratory Protection. Appendix C OSHA Respirator Medical Evaluation Questionnaire (Mandatory), pages 25 – 30.

Employee Signature: _____ Date: _____

EMU ID Number: _____

Please submit your form in a sealed envelope, marked confidential and submit it the Environmental Health and Safety either at 1200 Oakwood or 875 Ann Street, Suite 103.

Eastern Michigan University
Respirator Medical Evaluation
Results and Fit Testing

Employee Name: _____ EMU ID #: _____

MEDICAL EVALUATION

Approved: ☐

Approved with Restrictions: ☐
(Explain in Remarks)

Denied: ☐
(Explain in Remarks)

Remarks: _____

_____

_____

Medical Evaluator's Name (Please Print):_____ Date: _____

Medical Evaluator's Signature: _____

FIT TESTING

TEST METHOD: Saccharin Bitrex Irritant Smoke Isoamyl Acetate Quantative

RESPIRATOR:

Brand/Model #/Size#:	Type	Adjustment	NIOSH Approval
Other: _____			
For QLFT Please circle one: Pass Fail		For QNFT Please attach fit factor or other recording of QNFT fit test results	

Fit Tester's Name (Please Print):_____Date:_____

Fit Tester's Signature: _____