OhioHealth

Respiratory Protection Program
Initial Respirator Medical Evaluation Questionnaire

Section 1.
The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Name: _____ **Today's Date**: _____

Age (to nearest year):_____ **Date of Birth**: _____

Sex: Male ☐ Female ☐ **Height**: _____ft. _____in. **Weight**: _____lbs.

Phone number: (include area code)_____ (where you can be reached by the healthcare professional who will review this questionnaire)
The best time to call you at this number: _____am/pm

Job Title _____ **Unit**_____ **Campus** _____

Cost Center _____ **Clock#**_____ **Manager** _____

Has your employer told you how to contact the health care professional who will review this questionnaire?
Yes ☐ No ☐

Check the type of respirator you will use (you can check more than one category):
_____ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
_____Other types (for example, half or full-facepiece type, powered-air purifying, supplied air, self-contained breathing apparatus).

Have you worn a respirator? Yes ☐ No ☐
If "yes," what type? _____

This questionnaire is used to determine whether you have a medical condition that may affect your ability to wear a respirator. Most employees will be approved to wear respirators based on the information obtained from this questionnaire. In some cases, additional information may be requested. Fit testing of the respirator is also required and will be done separately. All medical information is considered confidential. This information will be included in your employee health file. Access to your employee health file will be in accordance with OSHA standard 1910.1020 and OhioHealth policy.

Employee Signature_____ Date _____

To Be Completed by Employee Health

Trainer Name_____

Will this person be a part of the hospital decontamination team? Yes ☐ No ☐

Medically cleared to use a negative pressure respirator without restrictions.	YES ☐	NO ☐
Medically cleared to use a positive pressure respirator without restrictions. (Includes Powered Air Purifying Respirators)	YES ☐	NO ☐

Further medical evaluations to be completed with annual fit testing and if associate shows signs and symptoms related to respirator use.

PLHCP Signature_____ Date_____

Section 2.

Occupational Safety and Health Administration
Initial Respirator Medical Evaluation Questionnaire

Name _____ **DOB** _____

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. Please explain if indicated. If your answer is no, please check box and go to next question. If your answer is yes, please check appropriate box.

1. Do you currently smoke tobacco, or have you smoked tobacco in the past month? ☐Yes ☐No

2. Have you ever had any of the following conditions? **NO** ☐

- Seizures (fits): YES ☐
- Diabetes (sugar disease): YES ☐
- Allergic reactions that interfere with your breathing: YES ☐
- Claustrophobia (fear of closed-in places): YES ☐
- Trouble smelling odors: YES ☐

****If yes, please explain:**_____

3. Have you ever had any of the following pulmonary or lung problems? **NO** ☐

- Asbestosis: YES ☐
- Asthma: YES ☐
- Chronic Bronchitis: YES ☐
- Emphysema: YES ☐
- Pneumonia: YES ☐
- Tuberculosis: YES ☐
- Silicosis: YES ☐
- Pneumothorax (collapsed lung): YES ☐
- Lung cancer: YES ☐
- Broken ribs: YES ☐
- Any chest injuries or surgeries: YES ☐
- Any other lung problem that you have been told about: YES ☐

****If yes, please explain:**_____

4. Do you currently have any of the following symptoms of lung illness? **NO** ☐

- Shortness of breath: YES ☐
- Shortness of breath when walking fast on level ground or walking up a slight hill or incline: YES ☐
- Shortness of breath when walking with other people at an ordinary pace on level ground: YES ☐
- Have to stop for breath when walking at your own pace on level ground: YES ☐
- Shortness of breath when washing or dressing yourself: YES ☐
- Shortness of breath that interferes with your job: YES ☐
- Coughing that produces phlegm (thick sputum): YES ☐
- Coughing that wakes you early in the morning: YES ☐
- Coughing that occurs mostly when you are lying down: YES ☐
- Coughing up blood in the last month: YES ☐
- Wheezing: YES ☐
- Wheezing that interferes with your job: YES ☐
- Chest pain when you breathe deeply: YES ☐
- Any other symptoms that you think may be related to lung problems: YES ☐

Name _____ **DOB** _____

****If yes, please explain:**_____

5. Have you ever had any of the following cardiovascular or heart problems? **NO** ☐

- Heart attack: YES ☐
- Stroke: YES ☐
- Angina: YES ☐
- Heart failure: YES ☐
- Swelling in your legs or feet (not caused by walking): YES ☐
- Heart arrhythmia (heart beating irregularly): YES ☐
- High blood pressure: YES ☐
- Any other heart problem that you have been told about: YES ☐

****If yes, please explain:**_____

6. Have you ever had any of the following cardiovascular or heart symptoms? **NO** ☐

- Frequent pain or tightness in your chest: YES ☐
- Pain or tightness in your chest during physical activity: YES ☐
- Pain or tightness in your chest that interferes with your job: YES ☐
- In the past two years, have you noticed your heart skipping or missing a beat: YES ☐
- Heartburn or indigestion that is not related to eating: YES ☐
- Any other symptoms that you think may be related to heart or circulation problems: YES ☐

****If yes, please explain:**_____

7. Do you currently take medication for any of the following problems? **NO** ☐

- Breathing or lung problems: YES ☐
- Heart trouble: YES ☐
- Blood pressure: YES ☐
- Seizures (fits): YES ☐

8. Are you taking any regular medications? YES ☐ NO ☐

****If yes, please list:**_____

_____

9. Do you have any medication allergies? YES ☐ NO ☐

****If yes, please list:**_____

10. Would you like to talk with the health care professional who will review this questionnaire about your answers to this questionnaire? YES ☐ NO ☐

**If yes, please call 614-566-5514 to speak with a health care professional.

All questions must be answered.

If questions are not answered, the form will be returned to you for completion.