ALLEGANY COLLEGE of MARYLAND

Respiratory Medical Questionnaire/ Examination

A.

Medical Evaluation Being Obtained For: _____

☐ Respirator Fit Testing

Employee/Student Name (First Name, Middle Initial Last Name) Today's Date

Sex Age Birthdate Race Height Weight
☐ Male ☐ Female

Program: _____

B. **To Be Completed by Employee/Student**

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?
   - ☐ Yes →Number years smoked: _____ Amount you smoke:_____
   - ☐ No → Month/Year you quit: _____

2. Put a check in the boxes below if you have **ever had** any of the following conditions:
   - ☐ Seizures (Epilepsy/Fits)
   - ☐ Diabetes (Elevated blood sugar)
   - ☐ Allergic reactions that interfere with breathing
   - ☐ Claustrophobia (Fear of closed-in places)
   - ☐ Trouble smelling odors

3. Put a check in the boxes below if you have ever had any of the following pulmonary or lung problems:
   - ☐ Asbestosis
   - ☐ Asthma
   - ☐ Chronic bronchitis
   - ☐ Emphysema
   - ☐ Pneumonia
   - ☐ Tuberculosis
   - ☐ Silicosis
   - ☐ Collapsed Lung
   - ☐ Lung cancer
   - ☐ Broken ribs
   - ☐ Any other chest injuries or surgeries

☐ Any other lung problems that you've been told about (i.e. pleurisy)

4. Put a check in the boxes below if you **currently have** any of the following symptoms of pulmonary or lung illness:
   - ☐ Shortness of breath
   - ☐ Shortness of breath when walking fast on level ground or walking up a slight hill or incline
   - ☐ Have to stop for breath when walking at your own pace on level ground
   - ☐ Shortness of breath when washing or dressing yourself
   - ☐ Shortness of breath that interferes with your job
   - ☐ Coughing that produces phlegm (thick sputum or mucous)
   - ☐ Coughing that wakes you early in the morning
   - ☐ Coughing that occurs mostly when you are lying down
   - ☐ Coughing up blood in the last month
   - ☐ Wheezing
   - ☐ Wheezing that interferes with your job
   - ☐ Chest pain when you breathe deeply
   - ☐ Any other symptoms that you think may be related to lung problems

5. Put a check in the boxes below if you have **ever had** any of the following cardiovascular or heart problems:
   - ☐ Heart attack
   - ☐ Stroke
   - ☐ Angina
   - ☐ Heart failure
   - ☐ Swelling in your legs or feet not caused by walking
   - ☐ Irregular heart rhythm
   - ☐ High blood pressure
   - ☐ Any other heart problem that you've been told about

6. Put a check in the boxes below if you **currently take** medication for any of the following problems:
   - ☐ Breathing or lung problems
   - ☐ Heart trouble
   - ☐ Blood pressure
   - ☐ Seizures (Epilepsy/Fits)

C. **Additional Information Requested by the Licensed Health Care Professional**

1. Are you taking medications for any reason? (Include those purchased over-the-counter.)

☐ No
☐ Yes

Name of Medication	Reason Taking
_____	_____
_____	_____
_____	_____
_____	_____

2. a. Have you ever worn a respirator?
   - ☐ No
   - ☐ Yes What type _____

   b. Have you experienced difficulty wearing a respirator?
   - ☐ No
   - ☐ Yes Explain _____

3. Have you had any illnesses, injuries, or medical problems since your last medical evaluation?
   - ☐ No
   - ☐ Yes Explain _____

4. Has your work ever been limited or restricted for medical reasons?
   - ☐ No
   - ☐ Yes Explain _____

5. Would you like to talk to a health care professional (who will review your questionnaire) about your answers?
   - ☐ No
   - ☐ Yes

I certify that my answers to this questionnaire are true, that I am physically and mentally able to perform all of the duties of my job, and that I know how to contact the Health Care Professional who will be reviewing this questionnaire. I understand that I may be required to see my physician for a medical examination and/or additional tests or procedures if I have "yes" answers to the questions in the questionnaire, or if I develop medical signs or symptoms related to my ability to use a respirator, of if my supervisor or the health care professional informs my employer that I need to be re-evaluated, or a change occurs in my workplace conditions that may affect my ability to wear a respirator.

Signature Date Signed

_____

References:

United States Department of Labor Occupational Safety and Health Administration. (2012, August). Retrieved from Appendix C of 29 CFR 1910.134: OSHA Respirator Medical Evaluation Questionnaire: https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134AppC