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| ***Part A. Section 1. The following information must be provided by every employee who has been selected to use any type of respirator (please print).*** | | | | | | |
| Can you read?  Yes  No | | Has your employer told you how to contact the health care professional who will review this questionnaire?  Yes  No | | | | |
| Date:Click or tap to enter a date. | Dept. Click or tap here to enter text. | | | DOB: | | Sex:  Male  Female |
| Name: Click or tap here to enter text. | | | Job Title: Click or tap here to enter text. | | | |
| Phone: Click or tap here to enter text. | | Best time to call: Choose an item. | Email: Click or tap here to enter text. | | | |
| ***Check the type of respirator you will use (you can check more than one category).*** | | | | | | |
| Don’t Know | N, R, or P disposable respirator (filtering facepiece/dust mask) | | | | | |
| Other (Elastomeric half or full-facepiece type reusable; powered-air purifying – PAPR; Supplied-air Respirator - SAR; Self-contained Breathing Apparatus SCBA) | | | | | | |
| Have you worn a respirator in the past year?  Yes  No | | | | | If yes, what type (s): Choose an item. | |

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| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Part A. Section 2. Questions 1 through 9 below must be answered by everyone who has been selected to use any type of respirator. | | | | | | | | 1. *Do you currently smoke tobacco, have you smoked tobacco in the last month:*  Yes  No | | | | | | | | 1. *Have you ever had any of the following conditions?*  Yes No | | | 1. *Check the box below* ***ONLY if you have*** *had any of the following pulmonary or lung problems?* | | | | | Seizures |  |  | Asbestosis |  | Silicosis |  | | Diabetes |  |  | Asthma |  | Collapsed Lung |  | | Claustrophobia |  |  | Chronic Bronchitis |  | Lung Cancer |  | | Trouble smelling odors |  |  | Emphysema |  | Broken Ribs |  | | Allergic reactions that effect breathing |  |  | Pneumonia |  | Chest Injuries or Surgeries |  | | Tuberculosis |  | Other lung problems |  |  1. *Do you currently have any of the following symptoms of pulmonary or lung illnesses below?* | |
| Shortness of breath (SOB) | |
| SOB when walking fast on level ground or walking up a slight hill or incline | |
| SOB when walking with other people at an ordinary pace on level ground | |
| Have to stop for breath when walking at your own pace on level ground | |
| When washing or dressing yourself | SOB that interferes with your job |
| Cough that produces phlegm (thick sputum) | Wheezing |
| Cough that wakes you early in morning | Wheezing that interferes with your job |
| Cough that occurs mostly when lying down | Chest pain when you breathe deeply |
| Coughed up blood in the last month | Any other symptoms related to lung problems |

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| **PHYSICIAN OR OTHER LICENSED HEALTH CARE PROFESSIONAL ONLY** | Yes | No |
| Further Medical Review Required? |  |  |
| Signature: | Date: Click or tap to enter a date. | |

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| 1. *Have you ever had any of the following cardiovascular or* ***heart problems****?* | |
| Heart attack | Swell in legs or feet, not caused by walking |
| Stroke | Heart arrhythmia (irregular heart beat) |
| Angina (chest pain or discomfort) | High blood pressure |
| Heart failure | Any other heart problem you’ve been told |
| 1. *Have you ever had any of the following cardiovascular or* ***heart symptoms****?* | |
| Frequent pain or tightness in your chest | |
| Pain or tightness in your chest during physical activity | |
| Pain or tightness in your chest that interferes with your job | |
| In the past two years, have you noticed your heart skipping or missing a beat | |
| Heartburn or indigestion that is not related to eating | |
| Any other conditions you think may be related to heart or circulation problems | |
| 1. *Do you currently take medication for any of the following problems?* | |
| Breathing or lung problems | Blood pressure |
| Heart trouble | Seizures (fits) |
| 1. *If you have used a respirator, have you ever had any of the following problems?* | |
| Eye irritation | Anxiety |
| Skin allergies | General weakness or fatigue |
| Any other problem that interferes with your use of a respirator?  NA  Please describe: | |
| 1. ***Would you like to talk to the licensed health care professional who will review this questionnaire about your answers?*** Yes  No | |

**Answer the following questions ONLY if you wear either a FULL FACEPIECE respirator**

**or SELF-CONTAINED BREATHING APPARATUS (SCBA)**

Which type of respirator do you use?  Full Facepiece  SCBA

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| Please check the condition below that applies to you: | | | |
| 1. Have you ever lost vision in either eye (temporarily or permanent)? | | | |
| 1. Do you currently have any of the following vision problems? | | | |
| Wear contact lenses | | Wear glasses | |
| Color Blind | | Any other eye or vision problem? | |
| 1. Have you ever had an injury to your ears, including a broken ear drum? | | | |
| 1. Do you currently have any of the following hearing problems? | | | |
| Difficulty hearing | Wear a hearing aid | | Any other hearing or ear problem |
| 1. Have you ever had a back injury? | | | |
| 1. Do you currently have any of the following musculoskeletal problems? | | | |
| Weakness in any of your arms, hands, legs, or feet | | | Back pain |
| Pain or stiffness when you lean forward or backward at the waist | | | |
| Difficulty fully moving your arms and legs | | Difficulty fully moving your head up and down | |
| Difficulty bending at your knees | | Difficulty fully moving your head side to side | |
| Climbing a flight of stairs or ladder carrying 25 lbs. | | | |
| Any other muscle or skeletal problem that interferes with using a respirator?  NA  Please describe: Click here to enter text. | | | |