



Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_ DOB: \_\_\_\_\_

**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.

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 (fits)  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 have 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 or 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 breath 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 problems that you have 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 2 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

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**Part A. Section 2. (Mandatory - continued)**

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 (fits)  Yes  No
8. If you have used a respirator, have you *ever had* any of the following problems?
- 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 speak with the reviewing health care professional 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-face piece 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

**Examiner Comments:**

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**Part B. Discretionary Questions**

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 are 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:

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3. Have you ever worked with any of the materials, or under any of the conditions listed below:

a. Asbestos	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Silica (e.g., sandblasting)	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Tungsten/cobalt (e.g., grinding or welding this material)	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Beryllium	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Aluminum	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Coal (e.g., mining)	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Iron	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Tin	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Dusty environments	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Any other hazardous exposures	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "yes," describe these exposures:

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4. List any second jobs or side businesses you have:

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5. List your previous occupations:

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6. List your current and previous hobbies:

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7. Have you been in the military services?  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:

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10. Will you be using any of the following items with your respirator(s)?

a. HEPA filters	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Canisters (e.g., gas masks)	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Cartridges	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Part B. (Discretionary questions - continued)**

11. How often are you expected to use the respirator(s)? (check all answers that apply to you)
- a. Escape only (no rescue duties)  Yes  No
  - b. Emergency rescue only  Yes  No
  - c. Less than 5 hrs. per week  Yes  No
  - d. Less than 2 hrs. per day  Yes  No
  - e. 2 to 4 hrs. per day  Yes  No
  - f. over 4 hrs. per day  Yes  No

12. During the period you are using your 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 are using your respirator?  Yes  No

If "yes," describe this protective clothing and/or equipment:

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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 will be doing while using your respirator(s):

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17. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases):

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18. Provide the following information, if you know it, for each toxic substance that you will be exposed to when 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: \_\_\_\_\_

Name of any other toxic substances that you will be exposed to while using your respirator(s):

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19. Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):