# Respirator Questionnaire

**Can you read?**

**Part A Section 1 (Mandatory)**

Your Name________________________________ Today's Date__________________
Age__________ Sex: ☐ Male ☐ Female Height_____________ Weight___________
Phone (______)________________ Best time to be reached: _________________
Employer __________________________________ Has your employer told you how to contact the health care professional who will receive this questionnaire? ☐ Yes ☐ No
Check the type(s) of respirator you will use:

☐ N, R, or P disposable respirator (filter mask, non-cartridge type only)
☐ Other type (for example: half or full face piece type, powered-air purifying, supplied air, self-contained breathing apparatus)

Have you worn a respirator? ☐ 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 check "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? (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 spaces) ☐ 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 in the early 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 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? ☐ 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 heart symptoms?
   a. Frequent pain or tightness in your chest? ☐ Yes ☐ No
   b. Pain or tightness in your chest that interferes with your job? ☐ Yes ☐ No
   c. Pain or tightness in your chest during physical activity? ☐ Yes ☐ No
   d. In the past two years, have you noticed you heart skipping at beat? ☐ Yes ☐ No
   e. Heartburn or indigestion that is not related to eating? ☐ Yes ☐ No
   f. Any other symptoms that you think might 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? (fits) ☐ Yes ☐ No
8. If you've used a respirator, have you ever had any of the following problems? (If you've 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

The preceding information is accurate to the best of my knowledge.

Signed____________________________________________ Date________________________

**Part B (Mandatory)**

Questions 10-15 must be answered by every employee who has been selected to use either 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 blindness? ☐ Yes ☐ No
    d. Any other vision problem? ☐ Yes ☐ No
12. Have you ever had any injury to your ears, including a broken eardrum? ☐ Yes ☐ No
13. Do you currently have any of the following hearing problems:
    a. Difficulty hearing? ☐ Yes ☐ No
    b. Wearing 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 and legs? ☐ 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 from side to side? ☐ Yes ☐ No
    g. Difficulty bending 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 pounds? ☐ Yes ☐ No
    j. Any other muscle or skeletal problem that interferes with using a respirator? ☐ Yes ☐ No

    Explain________________________________________________________

The preceding information is accurate to the best of my knowledge.

Signed____________________________________________ Date_______________________

# Respirator Use Statement

Employee______________________________ Employer______________________________

Date of evaluation______________________

1. Type of respirator to be used:
   ___________________________________________________________

2. Work exertion level (while wearing a respirator): ☐ Light ☐ Moderate ☐ Strenuous

3. Extent of usage: ☐ On a daily basis ☐ Occasionally (but more than once a week)
   ☐ Rarely, or for emergency situations only

4. Length of average work day in respirator: _____________________________________

5. Special work considerations (e.g. high places, temperature or humidity extremes, hazardous materials, other protective clothing worn, climbing, etc.):___________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

6. Any other relevant circumstances:_____________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

Person at your company who can answer questions regarding respirator use.

Name______________________________________ Phone___________________________

**MedStat must be supplied with a copy of your company's written respiratory protection program as required by 29CFR 1910.134**