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Southside West - Chesapeake, Suffolk, Portsmouth: 838 A Old George Washington Highway, Chesapeake, VA 23323, (757) 487-9600

Standard Respirator Questionnaire

Instructions:

Please use an ink pen and print legibly when filling out the questionnaire. All questions **must** be answered individually, by circling or checking the box. Drawing a line straight down the answers will not be acceptable.

The employer is required to provide you with the following information:

- Type and weight of the respirator.
- Duration and frequency of respirator use (including use for rescue and escape).
- Additional PPE to be used.
- Temperature and humidity extremes that may be encountered.

If for any reason the answer is not an absolute negative for **Part A, Section 2** or if any of the following occurs:

- If the employee reports medical signs or symptoms that are related to ability to use the respirator.
- A PLHCP, supervisor, or respirator program administrator, informs the employer that the employee needs to be reevaluated.
- Information from the respiratory protection program, including observations made during fit testing and program evaluation, indicate a need for evaluation.
- A change occurs in workplace conditions that may result in a substantial increase in the physiological burden placed on an employee.

a follow up medical examination may be required.

Employer: _____

Mandatory Respirator Medical Evaluation Questionnaire

Employer: Answers to questions in Section 1 and to question 9 in Section 2 of Part A do not require a medical examination.

Employee: Can you read? (Circle one) **Yes** **No**

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A Section 1. Mandatory

The following information must be provided by every employee who has been selected to use any type of respirator **Please print:**

1. Today's Date	2. Your Name	3. Your Age (to nearest year)	4. Sex (circle one)	5. Your height	6. Your weight
			M F	ft. ins.	lbs.
7. Your job title:					
8. A phone number where you can be reached by the health care professional who reviews this questionnaire: (include the Area Code) ()					
9. The best time to phone you at this number is:			10. Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one) Yes No		
11. Check the type of respirator you will use. (you can check more than one category)					
a. Disposable respirator (filter-mask, non cartridge type only) N (Not resistant) R (Resistant) P (Proof.oil)			b. Other types Half Face Piece Full Face Piece Powered Air Purifying Supplied Air SCBA (self-contained breathing apparatus)		
12. Have you worn a respirator? (circle one) 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 circle yes or no.

1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month?	Yes	No
2. Have you <i>ever</i> had any of the following conditions?		
a. Seizures (fits):	Yes	No
b. Diabetes (sugar diabetes):	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

Part A Section 2. Mandatory (continued)
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3. Have you <i>ever</i> 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 problems that you've been told about:	Yes	No

4. Do you <i>currently</i> 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 a 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 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 breathe deeply:	Yes	No
n. Any other symptoms that you think may be related to lung problems:	Yes	No

5. Have you <i>ever</i> 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 <i>ever</i> 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 two 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

Part A Section 2. Mandatory (continued)
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7. Do you <i>currently</i> 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):	Yes	No
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
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Full Facepiece or SCBA: Questions 10 to 15 below must be answered by every employee who has been selected to use either a full facepiece 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
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11. Do you <i>currently</i> 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 problems:	Yes	No

12. Have you <i>ever</i> had an injury to your ears, including a broken eardrum?	Yes	No
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13. Do you <i>currently</i> 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 <i>ever</i> had a back injury?	Yes	No
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15. Do you <i>currently</i> 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
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

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

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 feeling of dizziness, shortness of breath, pounding in you chest or other symptoms when you're 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:		

3. Have you ever worked with any of the materials, or under any of the conditions listed below?		
a. Asbestos:	Yes	No
b. Silica (e.g. in sandblasting):	Yes	No
c. Tungsten/cobalt (e.g. grinding or welding this material):	Yes	No
d. Beryllium:	Yes	No
e. Aluminum:	Yes	No
f. Coal (for example, mining):	Yes	No
g. Iron:	Yes	No
h. Tin:	Yes	No
i. Dusty environments:	Yes	No
j. Any other hazardous exposures:	Yes	No
If "yes," describe these exposures:		

4. List any second jobs or side businesses you have:
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5. List your pervious occupations:

6. List your current and previous hobbies:
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7. Have you ever 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
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Part B (continued)

16. Describe the work you'll be doing while you're using your respirator(s)

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

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of toxic substance	Estimated maximum exposure level per shift	Duration of exposure per shift

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

There's an I&O Medical Center Near You!

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