RESPIRATORY QUESTIONNAIRE
FOR RESPIRATOR USE

Section 1: Every employee who has been selected to use any type of respirator per the OSHA Respiratory Protection Standard 29 CFR 191 0.134 must provide the following information:

1. Today's Date _____
2. Name _____
3. Date of Birth _____
4. Sex (circle one) Male Female
5. Height _____ft. _____in.
6. Weight: _____lbs.
7. A telephone number where you can be reached by a health care professional who reviews this questionnaire (including area code) _____
8. The best time to phone you at this number _____
9. Has your employer told you how to contact the health care professional who will review this Questionnaire?

   ( ) Yes ( ) No
10. Have you ever worn a respirator? ( ) Yes ( ) No
11. Check the type of respirator you will use (you can check more than one category).

    ( ) dust mask (X) half-mask respirator (with filters)

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Section 2. Questions I 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 in the last month? ( ) Yes ( ) No

2. Have you ever had any of the following conditions?
   - ( ) seizures (fits)
   - ( ) diabetes (sugar disease)
   - ( ) allergic reactions to interfere with your breathing
   - ( ) claustrophobia (fear of closed-in places)
   - ( ) trouble smelling odors

   If you answered yes, please specify

   _____
   _____
   _____

3. Have you ever had any of the following pulmonary or lung problems?

( ) asbestosis	( ) tuberculosis	( ) broken ribs	( ) pneumothorax
( )asthma	( ) silicosis	( ) pneumonia	( ) any chest injury/surgery
( )chronic bronchitis	( ) emphysema	( ) lung cancer	( ) other lung problems

   If you answered yes, please specify

   _____
   _____
   _____

4. Do you currently have any of the following symptoms of pulmonary or lung problems?
   - ( ) shortness of breath
   - ( ) shortness of breath when walking fast on level ground or walking up a slight incline
   - ( ) shortness of breath when walking with other people at your ordinary pace on level ground
   - ( ) 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)
   - ( ) coughing that wakes you early in the morning
   - ( ) coughing that occurs mostly when you are lying down
   - ( ) 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

   If you answered yes, please specify

   _____
   _____
   _____

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5. Have you ever had any of the following cardiovascular or heart problems?

( ) heart attack ( ) high blood pressure
( ) angina ( ) heart failure
( ) stroke ( ) heart arrhythmia (irregular heart beat)
( ) swelling in your legs or feet (not caused by walking)
( ) any other heart problems you've been told about

If you answered yes, please specify

_____
_____
_____

6. Have you ever had any of the following cardiovascular or heart symptoms?

( ) frequent pain or tightness in the chest
( ) pain or tightness in your chest during physical activity
( ) pain or tightness in the 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 symptoms that you think may be related to heart or circulation problems

If you answered yes, please specify

_____
_____
_____

7. Do you currently take medication for any of the following problems?

( ) breathing or lung problems
( ) heart trouble
( ) blood pressure
( ) seizures (fits)

If you answered yes, please specify

_____
_____
_____

8. If you've used a respirator, have you ever had any of the following problems?

( ) eye irritation ( ) skin allergies or rashes
( ) anxiety ( ) general weakness or fatigue
( ) any other problem that interferes with your use of a respirator

9. Would you like to talk to a health care professional who will review this questionnaire about your answers to this questionnaire ( ) Yes ( ) No

_____ _____
Patient Signature Date