Can you read well enough to answer the questionnaire? Yes / No

Today's Date______________________ **Name**____ **Date of Birth**______________________

Age______________________________ **Gender**: ☐Male ☐Female **Height**:___________feet _____________inches **Weight**:________________pounds (lbs)

Phone Number (include area code)________________________ **Best time of day to call**_____________ **Job Title**____

1. Has your employer informed you about how to contact the health care professional who will review this questionnaire? ☐Yes ☐No

2. Check the type of respirator you will be using (select all that apply):

☐N, R, or P disposable respirator, filter mask, non-cartridge type only

☐Other type—half or full face piece type, powered air purifying, supplied air, self-contained breathing apparatus, etc.

3. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐Yes ☐No

4.

YES	*NO*	*Have you ever had any of the following conditions?*
☐	☐	Seizures (fits)
☐	☐	Diabetes
☐	☐	Allergic reactions that interfere with your breathing
☐	☐	Claustrophobia (fear of closed-in places)
☐	☐	Trouble smelling orders

5.

YES	*NO*	*Do you currently take medication for any of the following problems?*
☐	☐	Breathing or lung problems
☐	☐	Heart problems
☐	☐	Blood pressure
☐	☐	Seizures (fits)

6.

YES	*NO*	*Have you ever had any of the following pulmonary or lung problems?*	*YES*	*NO*	*Have you ever had any of the following pulmonary or lung problems?*
☐	☐	Asbestosis	☐	☐	Silicosis
☐	☐	Asthma	☐	☐	Pneumothorax (collapsed lung)
☐	☐	Chronic bronchitis	☐	☐	Lung cancer
☐	☐	Emphysema	☐	☐	Broken ribs
☐	☐	Pneumonia	☐	☐	Chest injuries or surgeries
☐	☐	Tuberculosis			
☐	☐	Any other lung problem, list problem(s) here ______________________________			

7.

YES	*NO*	*Do you currently have any of the following symptoms of pulmonary or lung illness?*
☐	☐	Shortness of breath
☐	☐	Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐	☐	Shortness of breath when walking with other people at an ordinary pace on level ground
☐	☐	Having 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 when you are lying down
☐	☐	Coughing up blood in the last month
☐	☐	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

8.

YES	*NO*	*Have you ever had any of the following?*	*YES*	*NO*	*Have you ever had any of the following?*
☐	☐	Heart attack	☐	☐	Swelling in your legs or feet, not caused by walking
☐	☐	Stroke	☐	☐	Heart arrhythmia (heart beating irregularly)
☐	☐	Angina (chest pain)	☐	☐	High blood pressure
☐	☐	Heart failure			
☐	☐	Any other heart problem, list problem(s) here ______________________________			

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9.

YES	NO	*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
☐	☐	Your heart skipping or missing a beat, in the past two years
☐	☐	Heartburn or indigestion that is not related to eating
☐	☐	Heart arrhythmia (heart beating irregularly)
☐	☐	High blood pressure
☐	☐	Any other symptoms that you think may be related to heart or circulation problems

10. Have you ever worn a respirator? ☐Yes (*please answer questions below)* ☐No (*skip to question 11*)

Type(s) of respirator worn____

YES	NO	*Did you have any of the following problems while using your respirator?*
☐	☐	Eye irritation
☐	☐	Skin allergies or rashes
☐	☐	Anxiety
☐	☐	General weakness or fatigue
☐	☐	Any other problem that interfered with your use of a respirator

Questions 11-16 are only required for employees who have 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 questions 11-16 is voluntary.

11. Have you ever lost vision in either eye? ☐Yes, temporarily ☐Yes, permanently ☐No

12.

YES	NO	*Do you currently have any of the following vision problems?*	YES	NO	*Do you currently have any of the following hearing problems?*
☐	☐	Wear contact lenses	☐	☐	Difficulty hearing
☐	☐	Wear glasses	☐	☐	Wear a hearing aid
☐	☐	Color blind	☐	☐	Any other ear or hearing problem, list problem(s) here ___________________________
☐	☐	Any other eye or vision problem, list problem(s) here ___________________________			

13. Have you ever had an injury to your ears, including a broken ear drum? ☐Yes ☐No

14. Have you ever had a back injury? ☐Yes ☐No

15.

YES	NO	*Do you currently have any of the following musculoskeletal problems?*	YES	NO	*Do you currently have any of the following musculoskeletal problems?*
☐	☐	Weakness in any of your arms, hands, legs, or feet	☐	☐	Difficulty fully moving your head side to side
☐	☐	Back pain	☐	☐	Difficulty squatting to the ground
☐	☐	Difficulty fully moving your arms and legs	☐	☐	Difficulty climbing a flight of stairs or a ladder
☐	☐	Pain or stiffness when you lean forward or backward at the waist	☐	☐	Difficulty carrying more than 25 pounds
☐	☐	Difficulty fully moving your head up or down	☐	☐	Any other muscle or skeletal problem that you think may interfere with using a respirator

16. Would you like to talk about your answers to this questionnaire with the healthcare professional who will be reviewing it? ☐Yes ☐No

Healthcare Professional Comments____

____

____

Patient Signature____ Date______________ Time________

Provider Signature____ Date______________ Time________

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