Respiratory Information Form

Employer Information (To be filled out by the employer prior to distributing this form to employee)

1. How often is the employee expected to use a respirator

Escape only (no rescue)	☐ Yes	☐ No
Emergency rescue only	☐ Yes	☐ No
Less than 5 hours per week	☐ Yes	☐ No
Less than 2 hours per day	☐ Yes	☐ No
2 to 4 hours per day	☐ Yes	☐ No
Over 4 hours per day	☐ Yes	☐ No

2. What will be the employee's work effort during the period of respirator use

☐ **Light:** sitting while writing, typing, drafting, performing light assembly work, standing while operating a drill press (1-3 lbs.), or controlling machines (less than 200 kcal per hour)

☐ **Moderate**: 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 (200 to 350 kcal per hour)

☐ **Heavy:** lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder, working on a loading dock, shoveling, walking up an 8-degree grade about 2 mph, climbing stairs with a heavy load (about 50 lbs.)

Employee Information Part A: Section 1 (Mandatory)

First Name	Middle Name	Last Name

Date	Employer	Job Title	Location

Date of Birth	Age (to nearest year)	Last 4 SSN	Sex	Height	Weight
			☐ Male ☐ Female	ft. in.	

Physical Address

City	State	Zip Code

Phone Number	Best time to call

Has your employer told you how to contact the health care provider who is reviewing this form? (See Contact Above) ☐ Yes ☐ No

Check the type of respirator you will use (you can check more than one category)

☐ NaCl (N), Oil Resistant (R), or Very Oil Resistant (P), disposable respirator (Filer-mask, non-cartridge type only)

☐ Other type (half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

Have you ever worn a respirator? ☐ Yes ☐ No | If yes, what types?

Employee Information Part A : Section 2 (Mandatory)

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

Employee Name First: Middle: Last:

2.	Have you ever had any of the following conditions:		
	Seizures	☐ Yes	☐ No
	Diabetes (sugar disease)	☐ Yes	☐ No
	Allergic reactions that interfere with our breathing	☐ Yes	☐ No
	Claustrophobia (fear of closed-in places)	☐ Yes	☐ No
	Trouble smelling odors	☐ Yes	☐ No
	Nasal fractures or facial trauma If so, when?	☐ Yes	☐ No
3.	Have you ever had any of the following pulmonary or lung problems:		
	Asthma	☐ Yes	☐ No
	Asbestosis	☐ Yes	☐ No
	Chronic Bronchitis	☐ Yes	☐ No
	Pneumonia	☐ Yes	☐ No
	COPD / Emphysema	☐ Yes	☐ No
	Tuberculosis	☐ Yes	☐ No
	Silicosis	☐ Yes	☐ No
	Pneumothorax (collapsed lung)	☐ Yes	☐ No
	Lung Cancer	☐ Yes	☐ No
	Broken Ribs	☐ Yes	☐ No
	Any chest injury or surgeries	☐ Yes	☐ No
	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:		
	Shortness of breath	☐ Yes	☐ No
	Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐ Yes	☐ No
	Shortness of breath when walking with other people at an ordinary pace on level ground	☐ Yes	☐ No
	Have to stop for breath when walking at your own pace on level ground	☐ Yes	☐ No
	Shortness of breath when washing or dressing yourself	☐ Yes	☐ No
	Shortness of breath that interferes with your job	☐ Yes	☐ No
	Coughing that produces phlegm (thick sputum)	☐ Yes	☐ No
	Coughing that wakes you early in the morning	☐ Yes	☐ No
	Coughing that occurs mostly when you are lying down	☐ Yes	☐ No
	Coughed up blood in the last month	☐ Yes	☐ No
	Wheezing	☐ Yes	☐ No
	Wheezing that interferes with your job	☐ Yes	☐ No
	Chest pain when you breathe deeply	☐ Yes	☐ No
	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 problem:		
	Heart attack	☐ Yes	☐ No
	Stroke	☐ Yes	☐ No

Employee Name First: Middle: Last:

Angina (pressure chest pain)	☐ Yes	☐ No
Heart failure (fluid build-up in your lungs or legs)	☐ Yes	☐ No
Swelling in your legs or feet (not caused by walking)	☐ Yes	☐ No
Heart arrhythmia (heart beating irregularly)	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Any other heart problem that you've been told about	☐ Yes	☐ No
6. Have you ever had any of the following cardiovascular or heart symptoms:		
Frequent pain or tightness in your chest	☐ Yes	☐ No
Pain or tightness in your chest during physical activity	☐ Yes	☐ No
Pain or tightness in your chest that interferes with your job	☐ Yes	☐ No
In the past two years, have you noticed your heart skipping or missing a beat	☐ Yes	☐ No
Heartburn or indigestion that is not related to eating	☐ Yes	☐ No
Any other symptoms that you think may be related to heart or circulation problems	☐ Yes	☐ No
7. Do you currently take medication for any of the following problems:		
Breathing or lung problems	☐ Yes	☐ No
Heart trouble	☐ Yes	☐ No
Blood pressure	☐ Yes	☐ No
Seizures	☐ 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 never used and skip to question 9.	☐ Never used	
Eye irritation	☐ Yes	☐ No
Skin allergies or rashes	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
General weakness or fatigue	☐ Yes	☐ No
Any other problem that interferes with your use of a respirator	☐ Yes	☐ No
9. Would you like to talk to the health professional who will receive this questionnaire about your answers?	☐ Yes	☐ No

Questions 10-15 must be answered by everyone 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 the following 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:		
Wear contact lenses	☐ Yes	☐ No
Wear glasses	☐ Yes	☐ No
Color blind	☐ Yes	☐ No
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

Employee Name	First:	Middle:	Last:

13.	Do you currently have any of the following hearing problems:		
	Difficulty hearing?	☐ Yes	☐ No
	Wear a hearing aid?	☐ Yes	☐ No
	Any other hearing or ear problem?	☐ Yes	☐ No
14.	Have you had a back injury?	☐ Yes	☐ No
15.	Do you currently have any of the following musculoskeletal problems:		
	Weakness in any of your arms, hands, legs, or feet	☐ Yes	☐ No
	Back pain	☐ Yes	☐ No
	Difficulty fully moving your arms and legs	☐ Yes	☐ No
	Pain or stiffness when you lean forward or backward at the waist	☐ Yes	☐ No
	Difficulty fully moving your head up or down	☐ Yes	☐ No
	Difficulty fully moving your head side to side	☐ Yes	☐ No
	Difficulty bending at your knees	☐ Yes	☐ No
	Difficulty squatting to the ground	☐ Yes	☐ No
	Climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐ Yes	☐ No
	Any other muscle or skeletal problem that interferes with using a respirator	☐ Yes	☐ No
16.	Will additional protective clothing be worn by you while wearing a respirator?	☐ Yes	☐ No
	If yes, please describe		
17.	Will you be working under hot conditions (temperatures exceeding 77˚F)?	☐ Yes	☐ No
18.	Will you be working under humid conditions?	☐ Yes	☐ No
19.	Have you ever worked with any other materials, or under any of the conditions listed below:		
	Asbestos	☐ Yes	☐ No
	Silica (sandblasting)	☐ Yes	☐ No
	Tungsten/cobalt (grinding or welding of these materials)	☐ Yes	☐ No
	Beryllium	☐ Yes	☐ No
	Aluminum	☐ Yes	☐ No
	Coal (for example, mining)	☐ Yes	☐ No
	Iron	☐ Yes	☐ No
	Tin	☐ Yes	☐ No
	Dusty environments	☐ Yes	☐ No
	Any other hazardous exposures	☐ Yes	☐ No
	If yes, please describe:		