THE Healthy Worker

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RESPIRATORY QUESTIONNAIRE

Part 1 – Employee Background Information

1. Today's Date _____

2a. Name _____ 2b. Company or agency _____

3. Age _____3a. Date of birth _____ 4. Sex Male Female

5. Height_____ feet ____ inches 6. Weight ___ pounds 7. Job title _____

8. Phone number where you can be reached by the health care professional who will review this form (_____)_____
9. The best time to telephone you at this number (time)_____ (circle one) am pm
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 (check all that apply)
☐ Disposable Filtering Dust Mask ☐ Half Mask ☐ Full-Face Mask ☐ Helmet or Hood ☐ Airline
☐ Non-Powered Cartridge or Canister ☐ Powered Air-Purifying Respirator ☐ Self-Contained Breathing Apparatus SCBA

12.Have you worn a respirator? (circle one) Yes No If yes, what type(s)? _____

Part 2 – General Health Information

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	☐ Yes	☐ No
b. Diabetes (sugar disease)	☐ 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
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. Other lung problems 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 walking fast on level ground or walking up a hill	☐ Yes	☐ No
c. Shortness of breath walking with people at 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 ever 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 (heart beating irregularly) ☐ 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 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

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 (skip to 9 if not applicable) ☐ Yes ☐ No
a. Eye irritation ☐ Yes ☐ No
b. Skin allergies ☐ 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 a health care professional who will review this questionnaire about your answers ☐ Yes ☐ No

Part 3 – Additional Questions for Users of Full-face Respirators or SCBA

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 blind ☐ Yes ☐ No
d. Any other eye or vision problems ☐ Yes ☐ No

12. Have you ever had any injury to yours ears, including a broken ear drum? ☐ Yes ☐ No

13. Do you currently 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 problems ☐ Yes ☐ No

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

15. Do you currently have any of the following musculoskeletal problems?
a. Weakness in any of your arms, hand, 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 and down ☐ Yes ☐ No
f. Difficulty fully moving your head side to side ☐ Yes ☐ No
g. Difficulty bending at 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 respiratory ☐ Yes ☐ No