Respiratory Fitness Questionnaire

Date:______________

Are you able to read? (Check One): ☐ Yes ☐ No

Part A. Section 1 (Mandatory):

Instructions: The following information must be provided by every employee who has been selected to use any type of respirator (Please Print)

Today's Date: ______________________________
Name: ______________________________
Age: ____________ Date of Birth: ______________________
Sex: ☐ Male ☐ Female
Height: ____________ Ft. ____________ In.
Weight: ________ Lbs.
Job Title: ______________________________
Social Security Number ______________________________
Phone Number: ______________________________
Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No
Type of Respirator: ☐ N, R, or P Disposable Respirator ☐ Other ____________________
Have you worn a respirator? (Check One) ☐ Yes ☐ No If Yes, what types ____________

Part A. Section 2. (Mandatory):

Instructions: Questions 1-9 below must be answered by every employee who has been selected to use any type of respirator (Check Yes or No)

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 (fits): ____ 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. Any other lung problems that you've been told about: ____ Yes ____ No

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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 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 an ordinary place 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? (If you've never used a respirator, check the following space and go to question 9): _____
   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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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
11. Do you **currently** have any of the following hearing problems?
    a. Wear contact lenses: ____ Yes ____ No
    b. Wear glasses: ____ Yes ____ No
    c. Color Blind: ____ Yes ____ No
    d. 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
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 problem: ____ Yes ____ No
14. Have you **ever had** a back injury: ____ Yes ____ No
15. Do you **currently** 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
    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 lbs: ____ Yes ____ No
    j. Any other muscle or skeletal problem that interferes with using a respirator: ____ Yes ____ No
16. 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: ____
    ____
    ____

17. 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: ____
____

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18. List any second jobs or side businesses you have: ____
____
____
19. List your previous occupations/jobs: ____
____
____
20. List your current and previous hobbies: ____
____
____
21. Have you been in the military services? ____ Yes ____ No

If "Yes", were you exposed to biological or chemical agents (either in training or combat): ____ Yes ____ No

22. Have you ever worked on a HAZMAT team? ____ Yes _____ No
23. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): ____ Yes ____ No

If "Yes" name the medications if you know them: ____

24. Will you be using any of the following items with your respirator(s)?
    a. HEPA Filters: ____ Yes ____ No
    b. Canisters (for example, gas masks): ____ Yes ____ No
    c. Cartridges: ____ Yes ____ No
25. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:
    a. Escape only (no rescue): ____ Yes ____ No
    b. Emergency rescue only: ____ Yes ____ No
    c. Less than 5 hours **per week**: ____ Yes ___ No
    d. Less than 2 hours **per day**: ____ Yes ____ No
    e. 2 to 4 hours per day: ____ Yes ____ No
    f. Over 4 hours per day: ____ Yes ____ No
26. During the period you are using the respirator(s), is your work effort:
    a. **Light** (less than 200 kcal per hour): ____ Yes ____ No

    If "Yes", how long does this period last during the average shift: ______ hrs. ______ min.

    Examples of a light work effort are **sitting** while writing, typing, drafting, or performing light assembly work; or **standing** while operating a drill press (1-3 lbs.) or controlling machines.

    b. **Moderate** (200 to 350 kcal per hour): ____ Yes ____ No

    If "Yes", how long does this period last during the average shift: _____ hrs. ______ min.

    Examples of moderate work effort are **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.

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c. **Heavy** (above 350 kcal per hour): ____ Yes ____ No

If "Yes", how long does this period last during the average shift: _____ hrs. _____ min.

Examples of heavy work are **lifting** a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; **shoveling; standing** while bricklaying or chipping castings; **walking** up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.)

27. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using the respirator: ____ Yes ____ No

    If "Yes" describe this protective clothing and/or equipment: ____
    ____
    ____

28. Will you be working under hot conditions (temperature exceeding 77 ^{o} F): ____ Yes ____ No
29. Will you be working under humid conditions: ____ Yes ____ No
30. Describe the work you'll be doing while you're using your respirator(s): ________________________________

____
____

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

____
____

32. 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: ____

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

34. In your present job, are you working at high altitudes (over 5,000 ft.) or in a place that has lower than normal amounts of oxygen: ____ Yes ____ No

If "Yes", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: ____ Yes ____ No

Patient Signature: ____ Date: __________________________

Provider Signature: ____ Date: __________________________