



Alaska Occupational Health *Full Respirator Questionnaire*

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Name: _____ Date: _____ DOB: _____ SSN: _____

Sex: Male Female Age: _____ height: _____ weight: _____ Your job title _____

mailing address: _____ Company you work for: _____

Can you read? Yes No

Phone number where you can be reached in the day by the health care professional who reviews this questionnaire: _____ The best time to phone you at this number: _____

Has your employer told you how to contact the health care professional who will review this questionnaire:

Yes No

1. Have you worn a respirator? Yes No If "yes" what type

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

a. N,R, or P disposable respirator (filter-mask, non-cartridge type only)

b. Other type - please circle - half- or full-facepiece type, powered-air purifying, supplied-air, self contained breathing apparatus

3. Do you currently smoke tobacco, or have you in the last month? Yes No If Yes, how much? _____

4. Have you ever had any of the following conditions?

- | yes | no | yes | no | yes | no | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Any chest injuries or surgeries | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Broken ribs |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic reactions that interfere with breathing | <input type="checkbox"/> | <input type="checkbox"/> | Trouble smelling odors | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Claustrophobia (fear of closed-in spaces) | <input type="checkbox"/> | <input type="checkbox"/> | Asbestosis | <input type="checkbox"/> | <input type="checkbox"/> | Silicosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Lung Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumothorax (collapsed lung) | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Any other lung problems that you've been told you have? | | | | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |

Please explain any "yes" answers _____

5. Do you currently have any of the following symptoms of pulmonary or lung illness?

- | yes | no | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath when walking on level ground or up a slight hill or incline |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath when walking with other people at an ordinary pace on level ground |
| <input type="checkbox"/> | <input type="checkbox"/> | Have to stop for breath when walking at your own pace on level ground |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath when washing or dressing yourself |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath that interferes with your job |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing that produces phlegm (thick sputum) |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing that wakes you early in the morning |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing that occur mostly when you are lying down |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood in the last month |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing that interferes with your job |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain when you breathe deeply |
| <input type="checkbox"/> | <input type="checkbox"/> | Any other symptoms that you think may be related to lung problems |

Please explain any "yes" answers _____

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

- | yes | no | yes | no | yes | no | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Heart failure |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Swelling in your legs not caused by walking |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart arrhythmia (heart beating irregularly) | | | | <input type="checkbox"/> | <input type="checkbox"/> | Any other heart problems that you've been told about? |

Please explain any "yes" answers _____

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

- | | | |
|--------------------------|--------------------------|---|
| yes | no | |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent pain or tightness in your chest |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain or tightness in your chest during physical activity |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain or tightness in your chest that interferes with your job |
| <input type="checkbox"/> | <input type="checkbox"/> | In the past two years, have you noticed your heart skipping or missing a beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn or indigestion that is not related to eating |
| <input type="checkbox"/> | <input type="checkbox"/> | Other symptoms that you think may be related to heart or circulation problems |

Please explain any "yes" answers _____

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

- | | | | |
|--------------------------|--------------------------|-----------------------------|-------------------|
| yes | no | | please list below |
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing or lung problems. | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures. | _____ |

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

- | | | |
|--------------------------|--------------------------|--|
| yes | no | |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye irritation |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin allergy or rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Generalized weakness or fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Other problems that interfere with your use of a respirator? |

10. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire

- yes no

The next section of questions must be answered by every employee 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 these questions is voluntary.

11. Have you ever lost vision in either eye temporarily or permanently: yes no If yes, please explain _____

12. Do you currently have any of the following vision problem?

- | | | | | | |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|---------------------------------|
| yes | no | | yes | no | |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear contact lenses | <input type="checkbox"/> | <input type="checkbox"/> | Wear glasses |
| <input type="checkbox"/> | <input type="checkbox"/> | Color blindness | <input type="checkbox"/> | <input type="checkbox"/> | Any other eye or vision problem |

If yes, please explain: _____

13. Have you ever had an injury to your ears, including a broken ear drum: yes no

If yes, please explain: _____

14. Do you currently have any of the following hearing problems?

- | | | |
|--------------------------|--------------------------|---|
| yes | no | |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty hearing |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear a hearing aid |
| <input type="checkbox"/> | <input type="checkbox"/> | Any other hearing or ear problem? Please Describe |

15. Have you ever had a back injury: yes no If yes, please explain _____

16. Do you currently have any of the following musculoskeletal problems?

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| yes | no | | yes | no | |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness in any of your arms, hands, legs or feet | <input type="checkbox"/> | <input type="checkbox"/> | Back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty fully moving your arms and legs | <input type="checkbox"/> | <input type="checkbox"/> | Pain or stiffness when you lean forward or backward at the waist |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty fully moving your head up or down | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty fully moving your head side to side |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty bending at your knees | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty squatting to the ground |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Any other muscle or skeletal problem that interferes with using a respirator? | | | |

Please explain any "yes" answers _____

17. In your present job, are you working at high altitudes (over 5,000 feet) 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

18. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals come into skin contact with hazardous chemicals? yes no If "yes" name the chemicals if you know them: _____

19. Have you ever worked with any of the materials, or under any of the conditions listed below:

- | | | | | | |
|--------------------------|---|--------------------------|-------------------------------|--------------------------|--------------------------|
| yes | no | yes | no | yes | no |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Asbestos | | Silica (e.g. in sandblasting) | | Tungsten/cobalt |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Beryllium | | Aluminum | | Coal |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Iron | | Tin | | Dusty environments |
| <input type="checkbox"/> | <input type="checkbox"/> Any other hazardous exposures? _____ | | | | |

20. List any second jobs or side businesses you have: _____

21. List your previous occupations: _____

22. List your current and previous hobbies: _____

23. 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 If yes, please explain _____

24. Have you ever worked on a HAZMAT team? Yes No

25. 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," please list _____

26. Will you be using any of the following items with your respirator(s)?

- HEPA Filters Yes No Canisters Yes No Cartridges Yes No

27. How often are you expected to use the respirator(s)?

- Escape only (rescue) Emergency rescue only Less than 5 hours/week
 Less than 2 hours/day 2 to 4 hours per day Over 4 hours/day

28. During the period you are using the respirator(s) is your work effort:

- Light** (less than 200 kcal per hour) example: sitting, typing, drafting, standing while controlling machines

If so, how long does this period last during the average shift: _____

- Moderate** (200 to 350 kcal per hour) examples: 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

If so how long does this period last during the average shift: _____

- Heavy** (above 350 kcal per hour) examples: 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 at about 2 mph, climbing stairs with a heavy load (about 50 lbs)

If so how long does this period last during the average shift: _____

29. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?

- Yes No If "yes," describe this protective clothing and/or equipment _____

30. Will you be working in hot conditions (temperature above 77 degrees F)? Yes No

31. Will you be working under humid conditions? Yes No

32. Describe the work you'll be doing while you're using your respirator(s): _____

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

34. 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 Max exposure level per shift _____
Duration of exposure shift _____

Name of toxic substance _____
Estimated Max exposure level per shift _____
Duration of exposure shift _____

Name of toxic substance _____
Estimated Max exposure level per shift _____
Duration of exposure shift _____

Name of toxic substance _____
Estimated Max exposure level per shift _____
Duration of exposure shift _____

The name(s) of any other toxic substances that you'll be exposed to while using your respirator _____

35. 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) _____

Form completed by: _____ Date: _____

BELOW TO BE FILLED OUT BY ALASKA OCCUPATIONAL HEALTH PROFESSIONAL

Comments:

- Needs Examination
- Cleared for use of respirator

Signature: _____ Date: _____