



# Alaska Occupational Health Respirator Questionnaire

1919 Lathrop St. #203, Fairbanks, AK 99701  
(907)456-2825 fax 451-0742 www.acokhealth.com

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                       |   |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart attack  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart failure   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Angina  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swelling in your legs not caused by walking           |
| <input type="checkbox"/> | <input type="checkbox"/> | <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

Signature \_\_\_\_\_ Date \_\_\_\_\_

ALASKA OCCUPATIONAL HEALTH REVIEWER COMMENTS:

- Approved for work with 1/2 face respirator  
 Needs Examination

Reviewer Signature \_\_\_\_\_ Date reviewed \_\_\_\_\_