Respiratory Protection
Medical Surveillance Questionnaire

Attachment A

Part A. (Mandatory) Every employee who has been selected to use any type of respirator must provide the following information.

Section 1: Employee Identification

Name:		Home Phone:	
Date of Birth:		Work Phone:	
Social Security Number:		Gender:	
Job title:		Height (ft, in.):	
Supervisor:		Weight (lbs):	
Can you read English?		☐ Yes ☐ No	
Has your employer told you to how to contact the healthcare professional who will review this?		☐ Yes ☐ No	

Section 2: Current Respirator Use

Type of respirator you will use (you can select more than one).	☐ Filtering facepiece (N-95) ☐ Half facepiece ☐ Full facepiece	☐ PAPR ☐ SCBA ☐ Supplied Air				
Have you worn a respirator in the past?	☐ Yes ☐ No					
If yes, what type of respirator have you worn?	Brand		Model		Size	
Describe the job duties requiring the use of a respirator.						
Will there be physical exertion while wearing the respirator?	☐ None ☐ Mild ☐ Moderate ☐ Strenuous					
How long will you wear the respirator in a single day?	☐ Less than 4 hours/week ☐ Less than 2 hours/day ☐ 2-4 hours/day ☐ Over 4 hours/day					
Is protective clothing also worn?	☐ Yes ☐ No	Describe the clothing:				
Identify hazardous or special work conditions	☐ Confined Spaces ☐ Toxic Gases ☐ Asbestos ☐ Lead	Describe any other hazards:				

Part B. (Mandatory) Every employee who has been selected to use any type of respirator must provide the following information.

Section 1: Personal Medical Information

If this is an initial examination, give answers based on your entire work history. If this is a periodic examination, give answers based on the past year. Please answer all questions fully.

Do you smoke tobacco? (No = less than 20 packs per life-time or less than 1 per day per year)	☐ Never			
	☐ Within the Past Month			
	☐ Currently			
If yes, how many packs per day or pipes/cigars per week?	☐ ½ or less	☐ 1	☐ 2	☐ 2 or more
If yes, how many years have you smoked?	☐ 1-9	☐ 10-19	☐ 20-29	☐ 30 or more

Have you **ever** had any of the following conditions?	Seizures	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
	Diabetes	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No
	Rheumatic fever	☐ Yes ☐ No	Bladder disease	☐ Yes ☐ No
	Allergic reactions that interfere with breathing	☐ Yes ☐ No	Claustrophobia	☐ Yes ☐ No
			Can't smell odors	☐ Yes ☐ No
Have you **ever** had any of the following pulmonary or lung problems?	Asbestosis	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
	Asthma	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
	Chronic bronchitis	☐ Yes ☐ No	Lung cancer	☐ Yes ☐ No
	Pneumonia	☐ Yes ☐ No	Broken ribs	☐ Yes ☐ No
	Chest injuries/surgeries	☐ Yes ☐ No	Silicosis	☐ Yes ☐ No
	Collapsed lung	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No
	Common Cold	☐ Yes ☐ No	Other lung problem	☐ Yes ☐ No
Do you **currently** experience shortness of breath during any of the following activities?	Walking fast on level ground/up a slight incline	☐ Yes ☐ No	Walking at your own pace	☐ Yes ☐ No
	Walking with other people at an ordinary pace on level ground	☐ Yes ☐ No	Washing/dressing	☐ Yes ☐ No
			Any other time that interferes with job	☐ Yes ☐ No
Do you **currently** experience coughing?	That produces a phlegm (thick sputum)	☐ Yes ☐ No	That occurs mostly when lying down	☐ Yes ☐ No
	That wakes you early in the morning	☐ Yes ☐ No	That produces blood	☐ Yes ☐ No
Do you currently have any other symptoms of pulmonary or lung illness?	Wheezing	☐ Yes ☐ No	Chest pain when breathing deeply	☐ Yes ☐ No
	Wheezing that interferes with your job	☐ Yes ☐ No	Any other related symptoms	☐ Yes ☐ No
Have you **ever** had any of the following cardiovascular or heart problems?	Heart attack.	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
	Angina.	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
	Heart Failure.	☐ Yes ☐ No	Heart arrhythmia/ irregular heartbeat	☐ Yes ☐ No
	Swelling in your legs or feet (not caused by walking)	☐ Yes ☐ No	Any other heart problem.	☐ Yes ☐ No

Have you ever had any of the following cardiovascular or heart symptoms?	Frequent pain or tightness in your chest.	☐ Yes ☐ No	Your heart skipping or missing a beat.	☐ Yes ☐ No
	Chest pain/tightness during physical activity.	☐ Yes ☐ No	Heartburn not related to eating.	☐ Yes ☐ No
	Chest pain/tightness that interferes with the job.	☐ Yes ☐ No	Other heart symptoms	☐ Yes ☐ No
Do you currently take medication for any of the following problems?	Breathing/lung problems	☐ Yes ☐ No	Blood pressure	☐ Yes ☐ No
	Heart trouble	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Do you currently take medication for any of the following problems?	Breathing/lung problems	☐ Yes ☐ No	List any other medications you take now (including over-the-counter)	☐ Yes ☐ No
	Heart trouble	☐ Yes ☐ No		
	Blood pressure	☐ Yes ☐ No		
	Seizures	☐ Yes ☐ No		

If you have used a respirator in the past, have you ever had any of the following problems? (If you've never worn a respirator, proceed to the next question.)	☐ Eye Irritation
	☐ Skin allergies or rashes
	☐ General weakness or fatigue
	☐ Anxiety
	☐ Any other problem that interferes with your use of a respirator

Would you like to talk to the healthcare professional who will review this questionnaire about your answers?	**☐ Yes ☐ No**

Retain this form in employee's file in accordance with HIPAA regulations

Part C. (Supplemental) If you will be wearing a full facepiece or SCBA respirator, complete the following section. If not, please skip this section and sign at the bottom.				
Have you **ever** lost vision in either eye?		☐ Yes ☐ No	Have you **ever** had an injury to ears/eardrums	☐ Yes ☐ No
Do you **currently** have any of the following vision problems?	Wear contact lenses	☐ Yes ☐ No	Color blind	☐ Yes ☐ No
	Wear glasses	☐ Yes ☐ No	Any other eye or vision problem	☐ Yes ☐ No
Do you **currently** have any of the following hearing problems?	Difficulty hearing	☐ Yes ☐ No	Other hearing problems	☐ Yes ☐ No
	Wear a hearing aid	☐ Yes ☐ No		
Do you **currently** have any of the following musculoskeletal problems?	Weakness in arms, hands, legs, or feet.	☐ Yes ☐ No	Difficulty bending at knees.	☐ Yes ☐ No
	Difficulty fully moving arms and legs.	☐ Yes ☐ No	Difficulty squatting to the ground	☐ Yes ☐ No
	Pain/stiffness leaning forward/backward at waist.	☐ Yes ☐ No	Difficulty climbing stairs with > 25 lbs.	☐ Yes ☐ No
	Difficulty fully moving head up or down.	☐ Yes ☐ No	Other muscle/skeletal problems that interferes with respirator use.	☐ Yes ☐ No
	Difficulty fully moving head side to side.	☐ Yes ☐ No		
Have you **ever** had a back injury?		☐ Yes ☐ No	Do you currently have back pain?	☐ Yes ☐ No

I hereby certify that the above information is true and accurate to the best of my knowledge.	
Employee's Signature	**Date**

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