DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Enterprise Services
F-80934 (10/09)

RESPIRATORY PROTECTION HEALTH QUESTIONNAIRE

INSTRUCTIONS

To the Supervisors:

Completion of this questionnaire is required by OSHA regulation 1910.134, "Respiratory Protection" and it shall be completed by any employee who is issued, and expected to wear a respirator as part of their work at (Institution). In order for the Health Care Professional to complete this medical evaluation, the employee needs to be able to answer questions 1 through 9, Part B of the Respiratory Protection Health Questionnaire. New employees may especially need your assistance in completing this section. The questionnaire will be administered confidentially, during the employee's normal working hours (or at a time and place convenient to the employee) by the designated Health Care Professional.

To the Employees:

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, the designated Health Care Professional will review the questionnaire with you and provide you with an opportunity to ask any questions you might have. In some situations, you will be asked to have a medical examination or further testing to ensure that it is safe for you to use a respirator. If you are receiving a medical exam, you must give this questionnaire to the physician who is performing the exam (prior to being issued a respirator). It will be returned, to the Institution with the results of your exam.

PART I

SECTION A (Mandatory)
The following information must be provided by every employee who has been selected to use any type of respirator. Please print or type.

Date - Today	Name - Employee	Age	Gender
			☐ Male ☐ Female

Height	Weight	Job Title
ft. in.	lbs.	

Area Code/Telephone Number (where you can be reached by the health care professional reviewing the questionnaire.	Best Time to Reach You at this Number. ☐ a.m. ☐ p.m.	Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No

Respirator Type You Will Use (you may check more than one category)
☐ N, R, or P Disposal Respirator (filter mask, non-cartridge type only)
☐ Other (for example, half or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

Have you ever worn a respirator? ☐ Yes ☐ No
If "Yes", list type(s):

SECTION B (Mandatory)
Questions 1 - 9 below must be answered by every employee 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?

Yes	No	
☐	☐	a. Seizures (fits)
☐	☐	b. Diabetes (sugar disease)
☐	☐	c. Allergic reactions that interfere with your breathing
☐	☐	d. Claustrophobia (fear of close-in places)
☐	☐	e. Trouble smelling odors

3. Have you ever had any of the following pulmonary or lung problems?

Yes	No		Yes	No	
☐	☐	a. Asbestosis	☐	☐	g. Silicosis
☐	☐	b. Asthma	☐	☐	h. Pneumothorax (collapsed lung)
☐	☐	c. Chronic bronchitis	☐	☐	I. Lung cancer
☐	☐	d. Emphysema	☐	☐	j. Broken ribs
☐	☐	e. Pneumonia	☐	☐	k. Any chest injuries or surgeries
☐	☐	f. Tuberculosis	☐	☐	l. Any other lung problem you have been told about

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

Yes	No	
☐	☐	a. Shortness of breath
☐	☐	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐	☐	c. Shortness of breath when walking with other people at an ordinary pace on level ground
☐	☐	d. Must stop for breath when walking at your own pace on level ground
☐	☐	e. Shortness of breath when washing or dressing yourself
☐	☐	f. Shortness of breath that interferes with your job
☐	☐	g. Coughing that produces phlegm (thick sputum)
☐	☐	h. Coughing that wakes you early in the morning
☐	☐	I. Coughing that occurs mostly when you are lying down
☐	☐	j. Coughing up blood in the last month
☐	☐	k. Wheezing
☐	☐	l. Wheezing that interferes with your job
☐	☐	m. Chest pain when you breathe deeply
☐	☐	n. Any other symptoms that you think may be related to lung problems

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

Yes	No		Yes	No	
☐	☐	a. Heart Attack	☐	☐	e. Swelling in your legs or feet (not caused by walking)
☐	☐	b. Stroke	☐	☐	f. Heart arrhythmia (heart beating irregularly)
☐	☐	c. Angina	☐	☐	g. High blood pressure
☐	☐	d. Heart failure	☐	☐	h. Any other heart problem that you've been told about

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

Yes	No		Yes	No	
☐	☐	a. Frequent pain or tightness in your chest	☐	☐	d. In the past two years, have you noticed your heart skipping or missing a beat
☐	☐	b. Pain or tightness in your chest during physical activity	☐	☐	e. Heartburn or indigestion not related to eating
☐	☐	c. Pain or tightness in your chest that interferes with your job	☐	☐	f. Any other symptoms that you think may be related to heart or circulation problems

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

Yes	No	
☐	☐	a. Breathing or lung problems
☐	☐	b. Heart trouble
☐	☐	c. Blood pressure
☐	☐	d. Seizures (fits)

8. ☐ If you've never used a respirator, check the box and go to question 9.

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

Yes	No	
☐	☐	a. Eye irritation
☐	☐	b. Skin allergies or rashes
☐	☐	c. Anxiety
☐	☐	d. General weakness or fatigue
☐	☐	e. Any other problem that interferes with use of a respirator

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?
☐ Yes ☐ No

Questions 10 - 15 below 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.

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
☐	☐	b. Wear glasses
☐	☐	c. Color blind
☐	☐	d. Any other eye or vision problem

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
☐	☐	b. Wear a hearing aid
☐	☐	c. Any other hearing or ear problem

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

15. Do you currently have any of the following musculosketetal problems?

Yes	No		Yes	No	
☐	☐	a. Weakness in any of your arms, hand, legs, or feet	☐	☐	g. Difficulty bending at your knees
☐	☐	b. Back pain	☐	☐	h. Difficulty squatting to the ground
☐	☐	c. Difficulty fully moving your arms and legs	☐	☐	i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs
☐	☐	d Pain or stiffness when you lean forward or backward at the waist	☐	☐	j. Any other muscle or skeletal problem that interferes with using a respirator
☐	☐	e. Difficulty fully moving your head up or down			
☐	☐	f. Difficulty fully moving your head side to side			

PART II

Any of the following questions and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. 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

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemical (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals? ☐ Yes ☐ No

   If "Yes", name the chemical s if you know them:

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

Yes	No		Yes	No	
☐	☐	a. Asbestos	☐	☐	f. Coal (for example, mining)
☐	☐	b. Silica (e.g., in sandblasting)	☐	☐	g. Iron
☐	☐	c. Tungsten/cobalt (e.g., grinding or welding this material)	☐	☐	h. Tin
☐	☐	d. Beryllium	☐	☐	i. Dusty environments
☐	☐	e. Aluminum	☐	☐	j. Any other hazardous exposures

   If "Yes", describe these exposures:

4. List any second jobs or side businesses you have.

5. Previous Occupations

6. Current and Previous Hobbies

7. Have you been in the military service? ☐ Yes ☐ No

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

9. Other than medications for breathing and lung problems, 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", list the medications (if you know them):

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

Yes	No	
☐	☐	a. HEPA Filters
☐	☐	b. Canisters (for example, gas masks)
☐	☐	c. Cartridges

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

Yes	No	
☐	☐	a. Escape Only (no rescue)
☐	☐	b. Emergency rescue only
☐	☐	c. Less than 5 hours per week
☐	☐	d. Less than 2 hours per day
☐	☐	e. 2 to 4 hours per day
☐	☐	f. Over 4 hours per day

12. Work Effort During the Period You Are Using the Respirator(s) **(check all that apply)**

	Length of Time Work Effort Lasts During Ave. Shift *Hours*	*Minutes*	
☐ Light (less than 200 kcal per hour)			Sitting while writing, typing, drafting, or performing light assembly work: or standing while operating a drill press (1-3 lbs.) or controlling machines.
☐ Moderate (200 to 350 kcal per hour)			Sitting while nailing or filing; driving a truck or busy 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 and 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
☐ Heavy (above 350 kcal per hour)			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 a 8-degree grade about 2 mph., climbing stairs with a heavy load (about 50 lbs.).

13. Will you wear protective clothing and/or equipment (other than the respirator) when you use your respirator? ☐ Yes ☐ No
If "Yes", describe this protective clothing and/or equipment:

14. Will you work under hot conditions (temperatures exceeding 77 deg. F)? ☐ Yes ☐ No

15. Will you work under humid conditions? ☐ Yes ☐ No

16. Describe the work you will do while you are using your respirator(s).

17. Describe any special or hazardous conditions you might encounter when you are using your respirator(s). For example, confined spaces, life-threatening gases.

18. Toxic substances to which you will be exposed when using your respirator (if known).

Toxic Substance	Estimated Maximum Exposure Level per Shift	Duration of Exposure per Shift

19. Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others. For example, rescue and security.

Reviewed By **SIGNATURE -** Health Care Professional	Review and Signature Date