

Employee Name:

Date:

SSN:

<input type="checkbox"/> General weakness / fatigue	<input type="checkbox"/> Any other problems that interferes with your use of a respirator	
Would you like to talk to the health care professional who will review this questionnaire about your answers to the questionnaire?	Yes	No
This 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 (SCABA).		
Have you ever lost vision in either eye (temporary or permanently)?	Yes	No
Do you currently have any of the following vision problems?		
Wear contact lenses?	Yes	No
Wear glasses?	Yes	No
Color blind?	Yes	No
Any other eye or vision problem?	Yes	No
Have you ever had an injury to your ears, including a broken eardrum?	Yes	No
Do you currently have any of the following hearing problems?		
Difficulty hearing?	Yes	No
Wearing a hearing aid?	Yes	No
Any other hearing or ear problem?	Yes	No
Have you ever had a back injury?	Yes	No
Do you currently have any of the following musculoskeletal problems?		
Weakness in any of your arms, hands, legs, or feet?	Yes	No
Backpain?	Yes	No
Difficulty fully moving your arms and legs?	Yes	No
Pain or stiffness when you lean forward or backward at the waist?	Yes	No
Difficulty fully moving your head up or down?	Yes	No
Difficulty fully moving your head side to side?	Yes	No
Difficulty bending at your knees?	Yes	No
Difficulty squatting to the ground?	Yes	No
Climbing a flight of stairs or a ladder carrying more than 25 pounds?	Yes	No
Any other muscle or skeletal problem that interferes with using a respirator?	Yes	No
PART B		
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 are working under these conditions	Yes	No
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. If "yes" list name of chemicals: _____	Yes	No
Have you ever worked with any of the materials, or under any of the conditions, listed below: (Circle all that apply) asbestos silica tungsten/cobalt beryllium aluminum coal iron tin dusty environment any other hazardous exposures	Yes	No
If "yes" describe these exposures: _____		
Have you been in the military services	Yes	No
If "yes" were you exposed to biological or chemical agents (in training or combat)	Yes	No
Have you ever worked on a Hazmat team?	Yes	No
List any second jobs or side businesses you have.		
List your previous occupation.		
List medications you are taking for breathing and lung problems, heart trouble, blood pressure, and seizures (including over-the-counter medications)		
List all other medications and reasons for use		
How often are you expected to use the respirator? Circle all that apply	Less than 5 hours /week Less than 2 hours per day 2-4 hours per day Over 4 hours/day	
Escape only (no rescue)		
Emergency rescue only		

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Will you be using any of the following items with your respirator? Circle all that apply HEPA filter Canisters (e.g. gas masks) Cartridges	Yes	No
During the period you are using the respirator is your work effort: Light: sitting while writing, typing, drafting or performing light assembly work Moderate: sitting while nailing or filing, driving a truck or bus in traffic; walking; pushing Heavy: lifting 50 pound loads, shoveling; standing while bricklaying	__ Light __ Moderate __ Heavy	__ hrs __ min __ hrs __ min __ hrs __ min
Will you be wearing protective clothing and/or equipment when using the respirator	Yes	No
Will you be working under hot conditions (temperature exceeding 77F)	Yes	No
Will you be working under humid conditions:	Yes	No
Describe the work you'll be doing while you're using your respirator:		
Describe any special or hazardous conditions you might encounter when you're using your respiratory (for example, confined spaces, life-threatening gases)		
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 the first toxic substance		
Estimated maximum exposure level per shift		
Duration of exposure per shift		
Name of the second toxic substance		
Estimated maximum exposure level per shift		
Duration of exposure per shift		
The name of any other toxic substances that you'll be exposed to while using your respirator		

Signature of Employee

Print Name

Date

For Employee Health Unit Use Only	<input type="checkbox"/> Approved	<input type="checkbox"/> Approved with Restrictions	<input type="checkbox"/> Denied	<input type="checkbox"/> More information needed
	Restrictions/Remarks:			
	Signature (Employee Health Staff):			Date:
	Physician Signature:			Date: