



Respiratory Information Form

Employer Information (To be filled out by the employer prior to distributing this form to employee)

- How often is the employee expected to use a respirator

Escape only (no rescue)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emergency rescue only	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Less than 5 hours per week	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Less than 2 hours per day	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2 to 4 hours per day	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Over 4 hours per day	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- What will be the employee's work effort during the period of respirator use
 - Light:** sitting while writing, typing, drafting, performing light assembly work, standing while operating a drill press (1-3 lbs.), or controlling machines (less than 200 kcal per hour)
 - Moderate:** 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 (200 to 350 kcal per hour)
 - Heavy:** lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder, working on a loading dock, shoveling, walking up an 8-degree grade about 2 mph, climbing stairs with a heavy load (about 50 lbs.)

Employee Information Part A: Section 1 (Mandatory)

First Name		Middle Name		Last Name			
Date		Employer		Job Title		Location	
Date of Birth	Age (to nearest year)	Last 4 SSN	Sex		Height	Weight	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	ft.	in.	
Physical Address							
City			State			Zip Code	
Phone Number				Best time to call			
Has your employer told you how to contact the health care provider who is reviewing this form? (See Contact Above) <input type="checkbox"/> Yes <input type="checkbox"/> No							

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

NaCl (N), Oil Resistant (R), or Very Oil Resistant (P), disposable respirator (Filter-mask, non-cartridge type only)

Other type (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, what types?

Employee Information Part A : Section 2 (Mandatory)

- Do you currently smoke tobacco, or have you smoked tobacco within the last month? Yes No



Employee Name First: Middle: Last:

2. Have you ever had any of the following conditions:

- Seizures
Diabetes (sugar disease)
Allergic reactions that interfere with our breathing
Claustrophobia (fear of closed-in places)
Trouble smelling odors
Nasal fractures or facial trauma If so, when?

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

- Asthma
Asbestosis
Chronic Bronchitis
Pneumonia
COPD / Emphysema
Tuberculosis
Silicosis
Pneumothorax (collapsed lung)
Lung Cancer
Broken Ribs
Any chest injury or surgeries
Any other lung problem that you've been told about

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

- Shortness of breath
Shortness of breath when walking fast on level ground or walking up a slight hill or incline
Shortness of breath when walking with other people at an ordinary pace on level ground
Have to stop for breath when walking at your own pace on level ground
Shortness of breath when washing or dressing yourself
Shortness of breath that interferes with your job
Coughing that produces phlegm (thick sputum)
Coughing that wakes you early in the morning
Coughing that occurs mostly when you are lying down
Coughed up blood in the last month
Wheezing
Wheezing that interferes with your job
Chest pain when you breathe deeply
Any other symptoms that you think may be related to lung problems

5. Have you ever had any of the following cardiovascular or heart problem:

- Heart attack
Stroke



Employee Name First: Middle: Last:

- Angina (pressure chest pain)
Heart failure (fluid build-up in your lungs or legs)
Swelling in your legs or feet (not caused by walking)
Heart arrhythmia (heart beating irregularly)
High blood pressure
Any other heart problem that you've been told about

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

- Frequent pain or tightness in your chest
Pain or tightness in your chest during physical activity
Pain or tightness in your chest that interferes with your job
In the past two years, have you noticed your heart skipping or missing a beat
Heartburn or indigestion that is not related to eating
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:

- Breathing or lung problems
Heart trouble
Blood pressure
Seizures

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

- If you've never used a respirator, check never used and skip to question 9.
Eye irritation
Skin allergies or rashes
Anxiety
General weakness or fatigue
Any other problem that interferes with your use of a respirator

9. Would you like to talk to the health professional who will receive this questionnaire about your answers?

Questions 10-15 must be answered by everyone 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 the following questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently)?

11. Do you currently have any of the following vision problems:

- Wear contact lenses
Wear glasses
Color blind
Any other eye or vision problem

12. Have you ever had an injury to your ears, including a broken ear drum?



Employee Name First: Middle: Last:

13. Do you currently have any of the following hearing problems:

- Difficulty hearing?
Wear a hearing aid?
Any other hearing or ear problem?

14. Have you had a back injury?

15. Do you currently have any of the following musculoskeletal problems:

- Weakness in any of your arms, hands, legs, or feet
Back pain
Difficulty fully moving your arms and legs
Pain or stiffness when you lean forward or backward at the waist
Difficulty fully moving your head up or down
Difficulty fully moving your head side to side
Difficulty bending at your knees
Difficulty squatting to the ground
Climbing a flight of stairs or a ladder carrying more than 25 lbs.
Any other muscle or skeletal problem that interferes with using a respirator

16. Will additional protective clothing be worn by you while wearing a respirator?

If yes, please describe

17. Will you be working under hot conditions (temperatures exceeding 77°F)?

18. Will you be working under humid conditions?

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

- Asbestos
Silica (sandblasting)
Tungsten/cobalt (grinding or welding of these materials)
Beryllium
Aluminum
Coal (for example, mining)
Iron
Tin
Dusty environments
Any other hazardous exposures

If yes, please describe:

Empty text box for description