KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest • Kaiser Foundation Hospitals

Respirator Certification Questionnaire

Patient Name:

HRN:

DOB:

Part A. Section 1

Every person who has been selected to use any type of respirator must provide the following information. (please print)

1. Employer Name: _____
2. Employer Address: _____
3. Today's Date: _____
4. Your Job Title: _____
5. Your age (to nearest year): _____
6. Your weight: _____ lbs.
7. Your Height: ft. _____ in. _____
8. Sex: ☐ Male ☐ Female
9. A phone number where you can be reached during the day by the health care professional who reviews this questionnaire.

   (Include the area code): _____
10. The best time to phone you at this number: _____
11. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No
12. Check the type of respirator you will use (you can check more than one category).

    ☐ N, R or P disposable respirator (filter-mask, non-cartridge type only).

    ☐ Other type (for example, half-or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

13. Have you previously worn a respirator? ☐ Yes ☐ No

    If "yes", what type(s) _____

Part A. Section 2

Every person who has been selected to use any type of respirator must answer questions 1 through 9 below (please 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?		
	a. Seizures (fits)	☐ Yes	☐ No
	b. Diabetes (blood sugar disease)	☐ Yes	☐ No
	c. Allergic reactions that interfere with your breathing	☐ Yes	☐ No
	d. Claustrophobia (fear of closed-in-places)	☐ Yes	☐ No
	e. Trouble smelling odors	☐ Yes	☐ No
3.	Have you ever had any of the following lung problems?		
	a. Asbestosis	☐ Yes	☐ No
	b. Asthma	☐ Yes	☐ No
	c. Chronic Bronchitis	☐ Yes	☐ No
	d. Emphysema	☐ Yes	☐ No
	e. Pneumonia	☐ Yes	☐ No
	f. Tuberculosis	☐ Yes	☐ No
	g. Silicosis	☐ Yes	☐ No
	h. Pneumothorax (collapsed lung)	☐ Yes	☐ No
	i. Lung caner	☐ Yes	☐ No
	j. Broken ribs	☐ Yes	☐ No
	k. Any chest injuries or chest surgeries	☐ Yes	☐ No
	l. Describe any other lung problems that you've been told about	☐ Yes	☐ No

_____

_____

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest • Kaiser Foundation Hospitals

Respirator Certification Questionnaire

Patient Name:

HRN:

DOB:

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

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

_____

_____

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

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

_____

_____

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

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

_____

_____

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

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

8. If you've ever used a respirator, have you ever had any of the following problems? ☐ Yes ☐ No
(If you've never used a respirator, check "no" and go to question 9)

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

_____

_____

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest • Kaiser Foundation Hospitals

Respirator Certification Questionnaire

Patient Name:

HRN:

DOB:

9.	Would you like to talk to the Kaiser Permanente physician who will review this questionnaire about your answers to this questionnaire?	☐ Yes	☐ No

Every person who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA) must answer questions 10-15 below. For persons 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	☐ Yes	☐ No
	b. Wear glasses	☐ Yes	☐ No
	c. Color blind	☐ Yes	☐ No
	d. Explain any other eye or vision problems:		
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	☐ Yes	☐ No
	b. Wearing a hearing aid	☐ Yes	☐ No
	c. Any other hearing or ear problem	☐ Yes	☐ No
14.	Have you ever had a back injury?	☐ Yes	☐ No
15.	Do you currently have any of the following musculoskeletal problems?		
	a. Weakness in any of your arms, and legs	☐ Yes	☐ No
	b. Back pain	☐ Yes	☐ No
	c. Difficulty fully moving your arms and legs	☐ Yes	☐ No
	d. Pain or stiffness when you lean forward or backward at the waist	☐ Yes	☐ No
	e. Difficulty fully moving your head up or down	☐ Yes	☐ No
	f. Difficulty fully moving your head side to side	☐ Yes	☐ No
	g. Difficulty bending at the knees	☐ Yes	☐ No
	h. Difficulty squatting to the ground	☐ Yes	☐ No
	i. Difficulty climbing a flight of stairs or a ladder carrying more than 25lbs	☐ Yes	☐ No
	j. Any other muscles or skeletal problem that interferes with using a respirator	☐ Yes	☐ No

Release of Information:

My signature on this form authorizes the release of the above information to my medical provider and authorizes my medical provider to release results to my employer.

Patient Signature Date