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 cancer  □ 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
      ____________________________________________________________
4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath at rest
   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. Have to 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 within 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 (list)

5. Have you ever had any of the following heart problems?
   a. Heart attack
   b. Stroke
   c. Angina (chest pain from the heart)
   d. Heart failure
   e. Swelling in your legs or feet (not caused by walking)
   f. Heart arrhythmia (heart beating irregularly)
   g. High blood pressure
   h. Any other heart problems that you’ve been told about (list)

6. Have you ever had any of the following heart symptoms?
   a. Frequent pain or tightness in your chest
   b. Pain or tightness in your chest during physical activity
   c. Pain or tightness in your chest that interferes with your job
   d. In the past two years, have you noticed your heart skipping or missing a beat
   e. Swelling in your legs or feet (not caused by walking)
   f. Heartburn or indigestion that is not related to eating
   g. Any other symptoms that you think may be related to heart or circulation problems (list)

7. Do you currently take medications for any of the following problems?
   a. Breathing or lung problems
   b. Heart trouble
   c. Blood pressure
   d. Seizures (fits)

8. If you’ve ever used a respirator, have you ever had any of the following problems?
   (If you’ve never used a respirator, check “no” and go to question 9)
   a. Eye irritation
   b. Skin allergies or rashes
   c. Anxiety
   d. General weakness or fatigue
   e. Any other problem that interferes with your use of a respirator
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 ___________