

Initial Questionnaire for Respirator Use

To the employee,

Please:

1. Complete the attached questionnaire.
2. Complete the attached OMS Clinical Record form. The OMS Clinical Record form will be used to establish or update your existing OMS medical record and to enroll you in the Respiratory Protection Program database.
3. Mail or deliver the completed forms to OMS. The OMS address is: Bldg. 10 6C306, MSC 1584.

Your supervisor:

- Must allow you to complete this questionnaire during normal working hours or at a time and place that is convenient to you.
- Must not review these forms, once you have completed them.

Has the medical clearance process been explained to you?

Yes

No

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Section 1 Please answer each question by printing your response or marking the correct answer.

1. Your name: _____
2. Last 4 digits of your Social Security Number: _____
3. Today's date: _____
4. Your age (to nearest year): _____
5. Your sex: Male Female
6. Your height: _____ ft. _____ in.
7. Your weight (lbs.): _____
8. Your job title: _____
9. A daytime phone number where you can be reached by the health care professional who reviews the questionnaire: _____
10. The best time to phone you at this number: _____
11. Check the type of respirator you will use (you can check more than one category):
 - a. N, R, or P disposable respirator (filter-mask, non-cartridge type only).
 - b. Other type (for example, half- or full-face-piece type, powered-air purifying, supplied-air, self-contained breathing apparatus [SCBA]).

Section 2 Please answer yes or no to the following questions. Yes No

12. Will you be expected to use the respirator daily?
13. Will you be expected to use the respirator more than 5 hours/week?
14. Will you be expected to exert significant effort while wearing it?
If "yes", please describe: _____
15. Have you worn a respirator before?
If "yes", what type(s): _____
16. Do you currently smoke tobacco or have you smoked tobacco in the last month?
17. Have you ever had any of the following conditions?
 - a. Seizures (fits)
 - b. Diabetes (sugar disease)
 - c. Allergic reactions that interfere with your breathing
 - d. Claustrophobia (fear of closed-in places)
 - e. Trouble smelling odors
18. Have you ever had any of the following pulmonary or lung problems?
 - a. Asbestosis
 - b. Asthma
 - c. Chronic bronchitis
 - d. Emphysema
 - e. Pneumonia

Yes No

- f. Tuberculosis
- g. Silicosis
- h. Pneumothorax (collapsed lung)
- i. Lung cancer
- j. Broken ribs
- k. Any chest injuries or surgeries
- l. Any other lung problem that you've been told about

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

- 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. 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 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

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

- a. Heart attack
- b. Stroke
- c. Angina
- 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 problem that you've been told about

21. Have you ever had any of the following cardiovascular or 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. Heartburn or indigestion that is not related to eating
- f. Any other symptoms that you think may be related to heart or circulation problems

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

- a. Breathing or lung problems
- b. Heart trouble
- c. Blood pressure
- d. Seizures (fits)

Yes No

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

(If you've never used a respirator, go to question 24).

- 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

24. Would you like to talk to an OMS medical provider about your answers on this questionnaire?

Section 3 Questions 25 through 30 below must be answered by every employee who has been selected to use either a full-face 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.

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

26. 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

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

28. 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

29. Have you ever had a back injury?

30. Do you currently have any of the following musculoskeletal problems?

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