CENTRA
EMPLOYEE HEALTH

Questionnaire for Respirator Users

(This form is for employees who need respiratory protection against M. Tuberculosis, SARS, or other particulates found in clinical areas.)

The Occupational Safety and Health Administration (OSHA) requires that the following information be provided by every employee who has been selected to use any type of respirator. If you have any questions regarding the first two pages, you may talk to your supervisor or call the Employee Health Office at 200-3082 or 4576.

Can you read?: ☐ YES ☐ NO

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your supervisor must not look at or review your answers to the medical portion of this questionnaire.

Name: _____ Work phone: _____
Employee Number: _____ Daytime phone: _____
Department: _____ Best time to call: _____
Job Title: _____ Sex: ☐ Male ☐ Female
Manager/Supervisor: _____ Date: _____

Check the type of respirator you will use in this job (you can check more then one category):

☒ N, R, or P disposable respirator ((filter-mask), non-cartridge type only)). (<1 lb)
☐ Air-purifying, half mask (<1 lb)
☐ Air-purifying, full mask (1-3 lbs)
☒ Powered air-purifying hood (<4-12 lbs)
☐ Powered air-purifying, tight fitting (<5 lbs)
☐ Supplied air, hood (<3 lbs)
☐ Other: _____
Use is: ☒ Required ☐ Voluntary

Please indicate your level of work effort while using the respirator, indicating the amount of time you would spend at each level in a day:

Level of Effort		Examples
☐ Light		Typing, operating a drill press, lifting up to 20 lbs
☐ Moderate	8-12 HRS	Nailing, assembly work, pushing a wheelbarrow on a level surface, lifting up to 50 lbs
☐ Heavy		Heavy lifting, shoveling, climbing stairs with a heavy load, lifting >100 lbs

How often are you expected to use the respirator?

☐ Escape only
☐ Emergency only
☐ <5 hours per week
☐ Daily, for < 2 hours per day
☐ Daily, for 2-4 hours per day
☐ Daily, more than 4 hours per day

Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ YES ☐ NO *__Call Employee Health at 200-3082 or 200-4576.__

Employee must fill out this section:

Age: _____ Weight: _____ Height: _____ Ft. _____ In.
Have you worn a respirator?: ☐ YES ☐ NO
IF YES, what type(s): _____

On the list below, please check any type of personal protective equipment you may be wearing when using your respirator.

☐ None	☐ Hearing protection	☐ Apron of lab coat
☐ Gloves	☐ Eye protection	☐ Hard hat
☐ Full body suit PPE	Other (please describe):	

Will you be working under hot conditions? (Above 85 deg. F): ☐ YES ☐ NO
Will you be working under humid conditions? ☐ YES ☐ NO

Describe the work you'll be doing while using your respirator(s): PATIENT CARE/ASSISTANCE

Describe any special or hazardous conditions you might encounter when using your respirator(s) (Example, confined spaces, life-threatening gases): NOT APPLICABLE

Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue or security): NOT APPLICABLE

Provide the following information, if you know it, for each potentially hazardous substance that you'll be exposed to when using your respirator(s).

Name of potentially hazardous substance	Estimated Maximum Exposure Level	Duration of exposure (# hours/week)
Airborne M. tuberculosis	Determined per shift	Determined by hours worked
Airborne SARS pathogen	Determined per shift	Determined by hours worked
Other airborne particulates	Determined per shift	Determined by hours worked

Questions 1 through 9 ** below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no"). Employee Health at 947-3082 or 947-4576 can assist you with this portion of the questionnaire.

	QUESTIONS	YES	NO
1.	**Do you currently smoke tobacco or have you smoked tobacco in the last month?**	☐	☐
2.	**Have you ever had any of the following conditions?**	☐	☐
	a) Seizures	☐	☐
	b) Diabetes (sugar disease)	☐	☐
	c) Allergic reactions that interfere with your breathing	☐	☐
	d) Claustrophobia (fear of closed-in places)	☐	☐
	e) Trouble smelling odors	☐	☐
	f) Heat stroke	☐	☐
3.	**Have you ever had any of the following pulmonary or lung problems?**		
	a) Asbestosis	☐	☐
	b) Asthma	☐	☐
	c) Chronic bronchitis	☐	☐
	d) Emphysema	☐	☐
	e) Pneumonia	☐	☐
	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	☐	☐

4.	**Have you ever had any of the following cardiovascular or heart problems?**		
	a) Heart attack	☐	☐
	b) Stroke	☐	☐
	c) Angina	☐	☐
	d) Swelling of your legs or feet (not caused by walking)	☐	☐
	e) Heart arrhythmia (heart beating irregularly)	☐	☐
	f) High blood pressure	☐	☐
	g) Any other heart problem that you've been told about	☐	☐
5.	**Do you currently have any of the following symptoms of pulmonary or lung illness?**		
	a) Shortness of breath	☐	☐
	b) Shortness of breath when walking	☐	☐
	c) Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
	d) Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
	e) Shortness of breath when walking at your own pace on level ground	☐	☐
	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 breath	☐	☐
	n) Any other symptoms that you think may be related to lung problems	☐	☐

	QUESTIONS	**YES**	**NO**
6.	**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 2 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	☐	☐
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 used a respirator, have you ever had any of the following problems?**		
	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 health care professional who will review this questionnaire about your answer to this questionnaire?**	☐	☐
	Briefly explain "YES" answers:		

For Healthworks / Employee Health use only:

Medically Approved for

☐ All air-purifying respirators ☐ Supplied air respirators
☒ Other: N95 Respirator

Restrictions:

☐ Employee may decline respirator-requiring assignments for temporary health-related difficulties
☐ Other:

Effective through: / or
☐ Complete brief questionnaire at time of annual employee medical screening.
Employee has been provided with a copy of this written recommendation: ☒ YES ☐ NO

*Signature of Physician or Other Licensed Health Care Professional Date

Signature of Licensed Health Care Professional (*if referred for Medical Provider review*) Date