



Respiratory Certification Questionnaire

Can you read?

Yes No (circle one)

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 employer or supervisor must not look at or review your answers and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

PART A. SECTION 1. The following information must be provided by every employee who has been selected to use any type selected to use any type of respirator. (Mandatory)

Please print

1. Today's date: _____
2. Your name: _____
3. Your age (to nearest year): _____
4. Sex (circle one): Male Female
5. Your height: _____ feet _____ inches
6. Your weight: _____ pounds
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire: _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire? Yes No (circle one)
11. Check the type of respirator you will use (you can check more than one category):

	N	R	P
a. N, R, or P disposable respirator (filter-mask, non-cartridge type only).			
b. Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).			
12. Have you worn a respirator? Yes No (circle one)
If yes, what types: _____

PART A. SECTION 2. The following information must be provided by every employee who has been selected to use any type of respirator. (Mandatory)

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month? Yes No (circle one)
2. Have you **ever had** any of the following conditions?

a. Seizures (fits):		Yes	No (circle one)
b. Diabetes (sugar disease):		Yes	No (circle one)
c. Allergic reactions that interfere with your breathing:		Yes	No (circle one)
d. Claustrophobia (fear of closed-in places):		Yes	No (circle one)
e. Trouble smelling odors:		Yes	No (circle one)
3. Have you **ever had** any of the following pulmonary or lung problems?

a. Asbestosis:		Yes	No (circle one)
b. Asthma:		Yes	No (circle one)
c. Chronic bronchitis:		Yes	No (circle one)
d. Emphysema:		Yes	No (circle one)
e. Pneumonia:		Yes	No (circle one)
f. Tuberculosis:		Yes	No (circle one)
g. Silicosis:		Yes	No (circle one)
h. Pneumothorax (collapsed lung):		Yes	No (circle one)
i. Lung cancer:		Yes	No (circle one)
j. Broken ribs:		Yes	No (circle one)
k. Any chest injuries or surgeries:		Yes	No (circle one)
l. Any other lung problem that you've been told about:		Yes	No (circle one)
4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath:		Yes	No (circle one)
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:		Yes	No (circle one)
c. Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes	No	(circle one)
d. Have to stop for breath when walking at your own pace on level ground:	Yes	No	(circle one)
e. Shortness of breath when washing or dressing yourself:	Yes	No	(circle one)
f. Shortness of breath that interferes with your job:	Yes	No	(circle one)
g. Coughing that produces phlegm (thick sputum):	Yes	No	(circle one)
h. Coughing that wakes you early in the morning:	Yes	No	(circle one)
i. Coughing that occurs mostly when you are lying down:	Yes	No	(circle one)
j. Coughing up blood in the last month:	Yes	No	(circle one)

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(Continued from previous page) 4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

- | | | | |
|---|-----|----|--------------|
| k. Wheezing: | Yes | No | (circle one) |
| l. Wheezing that interferes with your job: | Yes | No | (circle one) |
| m. Chest pain when you breathe deeply: | Yes | No | (circle one) |
| n. Any other symptoms that you think may be related to lung problems: | Yes | No | (circle one) |

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

- | | | | |
|---|-----|----|--------------|
| a. Heart attack: | Yes | No | (circle one) |
| b. Stroke: | Yes | No | (circle one) |
| c. Angina: | Yes | No | (circle one) |
| d. Heart failure: | Yes | No | (circle one) |
| e. Swelling in your legs or feet (not caused by walking): | Yes | No | (circle one) |
| f. Heart arrhythmia (heart beating irregularly): | Yes | No | (circle one) |
| g. High blood pressure: | Yes | No | (circle one) |
| h. Any other heart problem that you've been told about: | Yes | No | (circle one) |

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

- | | | | |
|---|-----|----|--------------|
| a. Frequent pain or tightness in your chest: | Yes | No | (circle one) |
| b. Pain or tightness in your chest during physical activity: | Yes | No | (circle one) |
| c. Pain or tightness in your chest that interferes with your job: | Yes | No | (circle one) |
| d. In the past two years, have you noticed your heart skipping or missing a beat: | Yes | No | (circle one) |
| e. Heartburn or indigestion that is not related to eating: | Yes | No | (circle one) |
| f. Any other symptoms that you think may be related to heart or circulation problems: | Yes | No | (circle one) |

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

- | | | | |
|--------------------------------|-----|----|--------------|
| a. Breathing or lung problems: | Yes | No | (circle one) |
| b. Heart trouble: | Yes | No | (circle one) |
| c. Blood pressure: | Yes | No | (circle one) |
| d. Seizures (fits): | Yes | No | (circle one) |

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9.)

- | | | | |
|---|-----|----|--------------|
| a. Eye irritation: | Yes | No | (circle one) |
| b. Skin allergies or rashes: | Yes | No | (circle one) |
| c. Anxiety: | Yes | No | (circle one) |
| d. General weakness or fatigue: | Yes | No | (circle one) |
| e. Any other problem that interferes with your use of a respirator: | Yes | No | (circle one) |

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

Yes No (circle one)

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece 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.

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

Yes No (circle one)

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

- | | | | |
|-------------------------------------|-----|----|--------------|
| a. Wear contact lenses: | Yes | No | (circle one) |
| b. Wear glasses: | Yes | No | (circle one) |
| c. Color blind: | Yes | No | (circle one) |
| d. Any other eye or vision problem: | Yes | No | (circle one) |

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

Yes No (circle one)

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

- | | | | |
|--------------------------------------|-----|----|--------------|
| a. Difficulty hearing: | Yes | No | (circle one) |
| b. Wear a hearing aid: | Yes | No | (circle one) |
| c. Any other hearing or ear problem: | Yes | No | (circle one) |

14. Have you **ever had** a back injury:

Yes No (circle one)

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

- | | | | |
|--|-----|----|--------------|
| a. Weakness in any of your arms, hands, legs, or feet: | Yes | No | (circle one) |
| b. Back pain: | Yes | No | (circle one) |
| c. Difficulty fully moving your arms and legs: | Yes | No | (circle one) |
| d. Pain or stiffness when you lean forward or backward at the waist: | Yes | No | (circle one) |
| e. Difficulty fully moving your head up or down: | Yes | No | (circle one) |
| f. Difficulty fully moving your head side to side: | Yes | No | (circle one) |
| g. Difficulty bending at your knees: | Yes | No | (circle one) |
| h. Difficulty squatting to the ground: | Yes | No | (circle one) |
| i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: | Yes | No | (circle one) |
| j. Any other muscle or skeletal problem that interferes with using a respirator: | Yes | No | (circle one) |

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PART B. SECTION 1. Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes No (circle one)

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes No (circle one)

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes No (circle one)

If "yes," name the chemicals if you know them:

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

- | | | | |
|---|-----|----|--------------|
| a. Asbestos: | Yes | No | (circle one) |
| b. Silica (e.g. , in sandblasting): | Yes | No | (circle one) |
| c. Tungsten/cobalt (e.g., grinding or welding this material): | Yes | No | (circle one) |
| d. Beryllium: | Yes | No | (circle one) |
| e. Aluminum: | Yes | No | (circle one) |
| f. Coal (for example, mining): | Yes | No | (circle one) |
| g. Iron: | Yes | No | (circle one) |
| h. Tin: | Yes | No | (circle one) |
| i. Dusty environments: | Yes | No | (circle one) |
| j. Any other hazardous exposures: | Yes | No | (circle one) |

If "yes," describe these exposures:

4. List any second jobs or side businesses you have:

5. List your previous occupations:

6. List your current and previous hobbies:

7. Have you been in the military services? Yes No (circle one)

If "yes," were you exposed to biological or chemical agents (in training or combat)? Yes No (circle one)

8. Have you ever worked on a HAZMAT team? Yes No (circle one)

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? Yes No (circle one)

If "yes," name the medications if you know them:

10. Will you be using any of the following items with your respirator(s)? Yes No (circle one)

- | | | | |
|--|-----|----|--------------|
| a. HEPA Filters: | Yes | No | (circle one) |
| b. Canisters (for example, gas masks): | Yes | No | (circle one) |
| c. Cartridges: | Yes | No | (circle one) |

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

- | | | | |
|--|-----|----|--------------|
| a. Escape only (no rescue): | Yes | No | (circle one) |
| b. Emergency rescue only: | Yes | No | (circle one) |
| c. Less than 5 hours per week : | Yes | No | (circle one) |
| d. Less than 2 hours per day : | Yes | No | (circle one) |
| e. 2 to 4 hours per day: | Yes | No | (circle one) |
| f. Over 4 hours per day: | Yes | No | (circle one) |

12. During the period you are using the respirator(s), is your work effort:

a. **Light** (less than 200 kcal per hour): Yes No (circle one)

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

*Examples of a light work effort are **sitting** while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.*

(Continued from previous page) 12. During the period you are using the respirator(s), is your work effort:

b. **Moderate** (200 to 350 kcal per hour): Yes No (circle one)

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

*Examples of moderate work effort are **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.*

Heavy (above 350 kcal per hour): Yes No (circle one)

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

*Examples of heavy work are **lifting** a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8 degree grad about 2 mph; climbing stairs with a heavy load (about 50 lbs.)*

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes No (circle one)

If "yes," describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperature exceeding 77 ° F): Yes No (circle one)

15. Will you be working under humid conditions: Yes No (circle one)

16. Describe the work you'll be doing while you're using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example: confined spaces, life-threatening gases, etc)

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

Name of the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances that you'll be exposed to while using your respirator: _____

19. 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, security):
