**Part A Section 1. (Mandatory)** The following information must be provided by every employee who has

been selected to use any type of respirator (please print).

1. Today's date:
2. Your name:
3. Your age (to nearest year):
4. Sex (circle one): Male/Female
5. Your height: ft. in.
6. Your weight: lbs.
7. Your job title:
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):
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 (circle one): Yes/No
11. Check the type of respirator you will use (you can check more than one category):
    1. N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    2. Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle one): Yes/No If “yes,” what type(s):

**Part A. Section 2. (Mandatory)** Questions 1 through 9 below must be answered by every employee who

has been selected to use any type of respirator (please circle “yes” or “no”).

## 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?  
   1. Seizures  
   2. Diabetes (sugar disease)  
   3. Allergic reactions that interfere with your breathing  
   4. Claustrophobia (fear of closed-in places)  
   5. Trouble smelling odors  
3. Have you *ever had* any of the following pulmonary or lung problems?  
   1. Asbestosis  
   2. Asthma  
   3. Chronic bronchitis  
   4. Emphysema  
   5. Pneumonia  
   6. Tuberculosis  
   7. Silicosis  
   8. Pneumothorax (collapsed lung)  
   9. Lung cancer  
   10. Broken ribs  
   11. Any chest injuries or surgeries  
   12. Any other lung problem that you've been told about  
4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?  
   1. Shortness of breath  
   2. Shortness of breath when walking fast on level ground or walking up a slight hill  

or incline

* 1. Shortness of breath when walking with other people at an ordinary pace on  

level ground

* 1. Have to stop for breath when walking at your own pace on level ground  
  2. Shortness of breath when washing or dressing yourself  
  3. Shortness of breath that interferes with your job  
  4. Coughing that produces phlegm (thick sputum)  
  5. Coughing that wakes you early in the morning  
  6. Coughing that occurs mostly when you are lying down  
  7. Coughing up blood in the last month  
  8. Wheezing  
  9. Wheezing that interferes with your job  
  10. Chest pain when you breathe deeply  
  11. Any other symptoms that you think may be related to lung problems  

1. Have you *ever had* any of the following cardiovascular or heart problems?
   1. Heart attack  
   2. Stroke  
   3. Angina  
   4. Heart failure  
   5. Swelling in your legs or feet (not caused by walking)  
   6. Heart arrhythmia (heart beating irregularly)  
   7. High blood pressure  
   8. Any other heart problem that you've been told about  
2. Have you *ever had* any of the following cardiovascular or heart symptoms?  
   1. Frequent pain or tightness in your chest  
   2. Pain or tightness in your chest during physical activity  
   3. Pain or tightness in your chest that interferes with your job  
   4. In the past two years, have you noticed your heart skipping or missing a beat  
   5. Heartburn or indigestion that is not related to eating  
   6. Any other symptoms that you think may be related to heart or circulation problems  
3. Do you *currently* take medication for any of the following problems?  
   1. Breathing or lung problems  
   2. Heart trouble  
   3. Blood pressure  
   4. Seizures  
4. 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.) 

* 1. Eye irritation  
  2. Skin allergies or rashes  
  3. Anxiety  
  4. General weakness or fatigue  
  5. Any other problem that interferes with your use of a respirator  

1. Would you like to talk to the health care professional who will review this questionnaire  

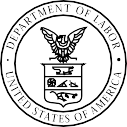
about your answers to this questionnaire?

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.

1. Have you *ever* lost vision in either eye (temporarily or permanently)?  
2. Do you *currently* have any of the following vision problems?  
   1. Wear contact lenses  
   2. Wear glasses  
   3. Color blind  
   4. Any other eye or vision problem  
3. Have you *ever had* an injury to your ears, including a broken eardrum?  
4. Do you *currently* have any of the following hearing problems?  
   1. Difficulty hearing  
   2. Wear a hearing aid  
   3. Any other hearing or ear problem  
5. Have you *ever had* a back injury?  
6. Do you *currently* have any of the following musculoskeletal problems?  
   1. Weakness in any of your arms, hands, legs, or feet  
   2. Back pain  
   3. Difficulty fully moving your arms and legs  
   4. Pain and stiffness when you lean forward or backward at the waist  
   5. Difficulty fully moving your head up or down  
   6. Difficulty fully moving your head side to side  
   7. Difficulty bending at your knees  
   8. Difficulty squatting to the ground  
   9. Climbing a flight of stairs or a ladder carrying more than 25 lbs.  
   10. Any other muscle or skeletal problem that interferes with using a respirator  

|  |  |  |
| --- | --- | --- |
| Name: | Date: | Comments/ Pass/ Fail/ |
| Reviewer  PHCLP: | Date: | * Forward for additional medical evaluation: * May participate in Fit Testing Training: * Exempt from Fit Test Training: * Limitations of Fit Test Training: * Limitations of N95 respirator use: |

This info sheet does not include the questions in Part B because they are not mandatory; rather, they may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.



**U.S. Department of Labor**