

THIS IS A TWO-PAGE DOCUMENT – BOTH PAGES MUST BE COMPLETED

OSHA respirator questionnaire

Print Name: _____ DOB: _____ Date: _____

Phone Number: _____ Employer: _____

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 mark "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?

YES / NO

- Seizures
 Diabetes (sugar disease)
 Allergic reactions that interfere with your breathing
 Claustrophobia (fear of closed-in places)
 Trouble smelling odors

3. Have you ever had any of the following pulmonary or lung problems?

YES / NO

- Asbestosis
 Asthma
 Chronic bronchitis
 Emphysema
 Pneumonia
 Tuberculosis
 Silicosis
 Pneumothorax (collapsed lung)
 Lung cancer
 Broken ribs
 Any chest injuries or surgeries
 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?

YES / NO

- Shortness of breath
 Shortness of breath when walking fast on level ground or walking up a slight hill or incline
 Shortness of breath when walking with other people at an ordinary pace on level ground
 Must stop for breath when walking at your own pace on level ground
 Shortness of breath when washing or dressing yourself
 Shortness of breath that interferes with your job
 Coughing that produces phlegm (thick sputum)
 Coughing that wakes you early in the morning
 Coughing that occurs mostly when you are lying down
 Coughing up blood in the last month
 Wheezing
 Wheezing that interferes with your job
 Chest pain when you breathe deeply
 Any other symptoms that you think may be related to lung problems

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

YES / NO

- Heart attack
- Stroke
- Angina
- Heart failure
- Swelling in your legs or feet (not caused by walking)
- Heart arrhythmia (heart beating irregularly)
- High blood pressure
- Any other heart problem that you've been told about

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

YES / NO

- Frequent pain or tightness in your chest
- Pain or tightness in your chest during physical activity
- Pain or tightness in your chest that interferes with your job
- In the past two years, have you noticed your heart skipping or missing a beat
- Heartburn or indigestion that is not related to eating
- Any other symptoms that you think may be related to heart or circulation problems

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

YES / NO

- Breathing or lung problems
- Heart trouble
- Blood pressure
- Seizures

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

YES / NO

- Eye irritation
- Skin allergies or rashes
- Anxiety
- General weakness or fatigue
- 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 answers to this questionnaire:

YES / NO

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For YES questions please explain:

Reviewer: _____ Date: _____