Respirator Clearance
Health History Questionnaire

Part A. Section 1. (please print).

1. Date____________________________ Dept/Organization____________________________________________
2. Last Name______________________ First Name______________________ MI_______
3. DOB: ____/____/________ Your age (to nearest year)_____________
4. Gender:   Male   Female
5. Your Height: ________ ft. ________ in.
6. Your Weight:___________lbs.
7. Your Job Title:________________________________________
8. Phone number where you can be reached by a health care professional who reviews this questionnaire (_____)(____)__________
9. Has your employer told you how to contact the health care professional who will review this questionnaire?    Yes       No
10. Check the type of respirator you will use (you can check more than one category):
    ____ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
    ____ Other type (half or full facepiece, powered air purifying, supplied-air, self-contained breathing apparatus)
    ____ Not applicable
11. Have you worn a respirator?    Yes          No      If yes, what type(s):______________________________________

Part A. Section 2.

1. ___Yes    ___No    Do you currently smoke tobacco or have you smoked tobacco in the last month?
2. Have you ever had any of the following conditions?
   ___Yes    ___No   a. Seizures (fits)
   ___Yes    ___No   b. Diabetes (sugar disease)
   ___Yes    ___No   c. Allergic Reactions that interfere w/breathing:
   ___Yes    ___No   d. Claustrophobia (fear of closed in spaces)
   ___Yes    ___No   e. Trouble smelling odors
3. Have you ever had any of the following pulmonary or lung problems?
   ___Yes    ___No   a. Asbestosis
   ___Yes    ___No   b. Asthma
   ___Yes    ___No   c. Chronic bronchitis
   ___Yes    ___No   d. Emphysema
   ___Yes    ___No   e. Pneumonia
   ___Yes    ___No   f. Tuberculosis
   ___Yes    ___No   g. Silicosis
   ___Yes    ___No   h. Pneumothorax (collapsed lung)
   ___Yes    ___No   i. Lung cancer
   ___Yes    ___No   j. Broken ribs
   ___Yes    ___No   k. Any chest injuries or surgeries
   ___Yes    ___No   l. Other lung problems you’ve been told about
Part A. Section 2. (cont)

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   ___Yes    ___No   a. Shortness of breath
   ___Yes    ___No   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
   ___Yes    ___No   c. Shortness of breath when walking with other people at an ordinary pace on level ground
   ___Yes    ___No   d. Have to stop for breath when walking at your own pace on level ground
   ___Yes    ___No   e. Shortness of breath when washing or dressing yourself
   ___Yes    ___No   f. Shortness of breath that interferes with your job
   ___Yes    ___No   g. Coughing that produces phlegm (thick sputum)
   ___Yes    ___No   h. Coughing that wakes you early in the morning
   ___Yes    ___No   i. Coughing that occurs mostly when you are lying down
   ___Yes    ___No   j. Coughing up blood in the last month
   ___Yes    ___No   k. Wheezing
   ___Yes    ___No   l. Wheezing that interferes with your job
   ___Yes    ___No   m. Chest pain when you breathe deeply
   ___Yes    ___No   n. Any other symptoms that you think may be related to lung problems

5. Have you ever had any of the following cardiovascular or heart problems?
   ___Yes    ___No   a. Heart attack
   ___Yes    ___No   b. Stroke
   ___Yes    ___No   c. Angina
   ___Yes    ___No   d. Heart failure
   ___Yes    ___No   e. Swelling in your legs or feet (not caused by walking
   ___Yes    ___No   f. Heart arrhythmia (irregular heart beat)
   ___Yes    ___No   g. High blood pressure
   ___Yes    ___No   h. 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   a. Frequent pain or tightness in your chest
   ___Yes    ___No   b. Pain or tightness in your chest during physical activity
   ___Yes    ___No   c. Pain or tightness in your chest that interferes with your job
   ___Yes    ___No   d. In the past two years, have you noticed your heart skipping or missing a beat
   ___Yes    ___No   e. Heartburn or indigestion that is not related to eating
   ___Yes    ___No   f. Any other symptoms that you may think are related to heart or circulation problems

7. Do you currently take medication for any of the following problems?
   ___Yes    ___No   a. Breathing or lung problems
   ___Yes    ___No   b. Heart trouble
   ___Yes    ___No   c. Blood pressure
   ___Yes    ___No   d. Seizures (fits)

8. If you’ve used a respirator, have you ever had any of the following problems? (check this question if you’ve never worn a respirator and move to question 9) ______
   ___Yes    ___No   a. Eye irritation
   ___Yes    ___No   b. Skin allergies or rashes
   ___Yes    ___No   c. Anxiety
   ___Yes    ___No   d. General weakness or fatigue
   ___Yes    ___No   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 answers?
   ___Yes    ___No
10. Have you ever lost vision in either eye? (temporarily or permanently)
___Yes    ___No

11. Do you currently have any of the following vision problems?
___Yes    ___No  a. Wear contact lenses
___Yes    ___No  b. Wear glasses
___Yes    ___No  c. Color blind
___Yes    ___No  d. Any other eye or vision problem

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

13. Do you currently have any of the following hearing problems?
___Yes    ___No  a. Difficulty hearing
___Yes    ___No  b. Wear a hearing aid
___Yes    ___No  c. Any other hearing or ear problem

14. Have you ever had a back injury?
___Yes    ___No

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

Part B. Other Questions

1. Have you had any change in your medical status since your last physical examination?
___Yes    ___No
   If Yes, please explain:__________________________________________________________

2. Do you currently wear a respirator?
___Yes    ___No
   If Yes, how often? (i.e. 20% of your shift, 1 hour a week, etc.)_____________________

3. Do you experience any health problems when you wear a respirator?
___Yes    ___No
   If Yes, please explain:__________________________________________________________

4. Based on your health status, do you have any questions or concerns about wearing a respirator?
___Yes    ___No
   If Yes, please explain:__________________________________________________________

5. Have you ever been in the military?
___Yes    ___No
   If Yes, were you exposed to biological or chemical agents during training or combat?____________________
I understand that all information provided in this questionnaire is retained in my confidential medical record. I certify that I have answered the above questions to the best of my abilities. I understand that only information related to my ability to perform the essential functions of my position would ever be released to my employer. All other information is part of my medical record and used for purposes of improving my overall health.

________________________________________________  _____________________________________________
Your Signature                                   Provider Signature

________________________________________________  _____________________________________________
Printed                                      Printed

________________________________________________  _____________________________________________
Date                                         Date