BRONSON

Affix Patient Label

Company Name: _____

Part A. Section 1 (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator. Your employer will expect 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, and you will be told how to deliver or send this questionnaire to the health professional who will review it.

Today's Date: _____Your Legal Name: _____
Social Security #:_____Date of Birth:_____ Sex:_____ Weight:_____ Job Title:_____
Home Phone Number:_____ Work Phone Number: _____ Best time to reach you at work: _____

Have you been told how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No

Check the type of respirator you will use (you can check more than one):

a. ☐ N, R, or disposable respirator (filter-mask, noncartilage type only).
b. ☐ Other type (for example, half-or-full-face piece type, powered air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator? ☐ Yes ☐ No If yes, what type? _____

Part A. Section 2. (Mandatory) Questions 1 through 8 below must be answered by every employee who has been selected to use any type of respirator.

	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 (fits):	☐	☐
b. Diabetes (sugar disease):	☐	☐
c. Allergic reactions that interfere with your breathing:	☐	☐
d. Claustrophobia (fear of closed in spaces):	☐	☐
e. Trouble smelling odors:	☐	☐
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:	☐	☐
i. Lung Cancer:	☐	☐
j. Broken ribs:	☐	☐
k. Any chest injuries or surgeries:	☐	☐
l. Another lung problem that you have been told about:	☐	☐

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?	**Yes**	**No**
a. Shortness of breath:	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground:	☐	☐

BRONSON

Affix Patient Label

d.	Have to stop for breath when walking at your own pace on level ground:	☐	☐
e.	Shortness of breath when washing or dressing yourself:	☐	☐
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 you job:	☐	☐
m.	Chest pain when you breathe deeply:	☐	☐
n.	Any other symptoms that you think you may be related to lung problems:	☐	☐

5. Have you **ever had** any of the following cardiovascular or heart problems?		**Yes**	**No**
a.	Heart attack:	☐	☐
b.	Stroke:	☐	☐
c.	Angina:	☐	☐
d.	Heart failure:	☐	☐
e.	Swelling in your legs or feet (not caused by walking):	☐	☐
f.	Heart arrhythmia (heart beating irregularly):	☐	☐
g.	High blood pressure:	☐	☐
h.	Any other heart problems that you have 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:	☐	☐
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 medication for any of the following problems?		**Yes**	**No**
a.	Breathing or lung problems:	☐	☐
b.	Heart trouble:	☐	☐
c.	Blood pressure:	☐	☐
d.	Seizures:	☐	☐

8. If you have used a respirator, have you **ever had** any of the following problems?		**Yes**	**No**
a.	Eye irritation:	☐	☐
b.	Skin allergies or rashes:	☐	☐
c.	Anxiety:	☐	☐
d.	General weakness or fatigue:	☐	☐
e.	Any other problem that interferes with the 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

Reviewed by:_____

BRONSON

Affix Patient Label

Questions 10 -15 to be completed only by employees who will be using a full-face respirator or a self-containing breathing apparatus (SCBA)

	Yes	No
10. Have you **ever lost** your vision in either eye (temporarily or permanently):	☐	☐
11. Do you **currently** have any of the following vision problems?		
a. Wear contact lens:	☐	☐
b. Wear glasses:	☐	☐
c. Color blind:	☐	☐
12. Have you **ever had** an injury to your ears, including a broken ear drum:	☐	☐
13. Do you **currently** have any of the following hearing problems?		
a. Difficulty hearing:	☐	☐
b. Wear a hearing aid:	☐	☐
c. Any other hearing or ear problem:	☐	☐
14. Have you **ever had** a back injury:	☐	☐
15. Do you **currently have** any of the following musculoskeletal problems?		
a. Weakness in your arms, hands, legs, or feet:	☐	☐
b. Back pain:	☐	☐
c. Difficulty fully moving your arms and legs:	☐	☐
d. Pain or stiffness when you lean forward or backward at the waist:	☐	☐
e. Difficulty fully moving your head up or down:	☐	☐
f. Difficulty fully moving your head side to side:	☐	☐
h. Difficulty bending your knees:	☐	☐
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.:	☐	☐
j. Any other muscle or skeletal problem that interferes with using a respirator:	☐	☐

Reviewed by:_____**Date:**_____**Time:**_____