



- ProHealth - John Street
- ProHealth - Elm Valley Dr.
- ProHealth - Paw Paw
- ProHealth - Vicksburg
- ProHealth - Battle Creek

Affix Patient Label

Can you read? Yes No

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

Would you like to talk to the health care professional who will review this questionnaire about your answers to 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:	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had any of the following conditions?		
a. Seizures (fits):	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease):	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing:	<input type="checkbox"/>	<input type="checkbox"/>
d. Claustrophobia (fear of closed in spaces):	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble smelling odors:	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis:	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma:	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic Bronchitis:	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema:	<input type="checkbox"/>	<input type="checkbox"/>
e. Pneumonia:	<input type="checkbox"/>	<input type="checkbox"/>
f. Tuberculosis:	<input type="checkbox"/>	<input type="checkbox"/>
g. Silicosis:	<input type="checkbox"/>	<input type="checkbox"/>
h. Pneumothorax:	<input type="checkbox"/>	<input type="checkbox"/>
i. Lung Cancer:	<input type="checkbox"/>	<input type="checkbox"/>
j. Broken ribs:	<input type="checkbox"/>	<input type="checkbox"/>
k. Any chest injuries or surgeries:	<input type="checkbox"/>	<input type="checkbox"/>
l. Another lung problem that you have been told about:	<input type="checkbox"/>	<input type="checkbox"/>

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|--|--------------------------|--------------------------|
| 4. Do you currently have any of the following symptoms of pulmonary or lung illness? | Yes | No |
| a. Shortness of breath: | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath when walking with other people at an ordinary pace on level ground: | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have to stop for breath when walking at your own pace on level ground: | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Shortness of breath when washing or dressing yourself: | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Shortness of breath that interferes with your job: | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Coughing that produces phlegm (thick sputum): | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Coughing that wakes you early in the morning: | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Coughing that occurs mostly when you are lying down: | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Coughing up blood in the last month: | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Wheezing: | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Wheezing that interferes with you job: | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Chest pain when you breathe deeply: | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Any other symptoms that you think you may be related to lung problems: | <input type="checkbox"/> | <input type="checkbox"/> |
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 | | |
| 5. Have you ever had any of the following cardiovascular or heart problems? | Yes | No |
| a. Heart attack: | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Stroke: | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Angina: | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Heart failure: | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Swelling in your legs or feet (not caused by walking): | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Heart arrhythmia (heart beating irregularly): | <input type="checkbox"/> | <input type="checkbox"/> |
| g. High blood pressure: | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Any other heart problems that you have been told about: | <input type="checkbox"/> | <input type="checkbox"/> |
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 | | |
| 6. Have you ever had any of the following cardiovascular or heart symptoms? | Yes | No |
| a. Frequent pain or tightness in your chest: | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Pain or tightness in your chest during physical activity: | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Pain or tightness in your chest that interferes with your job: | <input type="checkbox"/> | <input type="checkbox"/> |
| d. In the past 2 years, have you noticed your heart skipping or missing a beat: | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Heartburn or indigestion that is not related to eating: | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Any other symptoms that you think may be related to heart or circulation problems: | <input type="checkbox"/> | <input type="checkbox"/> |
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 | | |
| 7. Do you currently take medication for any of the following problems? | Yes | No |
| a. Breathing or lung problems: | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Heart trouble: | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Blood pressure: | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Seizures: | <input type="checkbox"/> | <input type="checkbox"/> |
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| 8. If you have used a respirator, have you ever had any of the following problems? | Yes | No |
| a. Eye irritation: | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Skin allergies or rashes: | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Anxiety: | <input type="checkbox"/> | <input type="checkbox"/> |
| d. General weakness or fatigue: | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Any other problem that interferes with the use of a respirator: | <input type="checkbox"/> | <input type="checkbox"/> |

Reviewed by: _____

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): | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you currently have any of the following vision problems? | | |
| a. Wear contact lens: | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear glasses: | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Color blind: | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had an injury to your ears, including a broken ear drum: | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you currently have any of the following hearing problems? | | |
| a. Difficulty hearing: | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear a hearing aid: | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any other hearing or ear problem: | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a back injury: | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you currently have any of the following musculoskeletal problems? | | |
| a. Weakness in your arms, hands, legs, or feet: | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Back pain: | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Difficulty fully moving your arms and legs: | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pain or stiffness when you lean forward or backward at the waist: | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Difficulty fully moving your head up or down: | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Difficulty fully moving your head side to side: | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Difficulty bending your knees: | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.: | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Any other muscle or skeletal problem that interferes with using a respirator: | <input type="checkbox"/> | <input type="checkbox"/> |

Reviewed by: _____ Date: _____ Time: _____