OSHA Respiratory Questionnaire for
Occupational Health Services

Your employer must allow 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 employer or supervisor must not look
at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the
healthcare professional who will review it. The effectiveness of this screening process is directly related to
the accuracy of the information the screening provider has access to. As such, the examinee assumes full
responsibility for any omissions of pertinent information or incomplete responses to the questionnaire that
can compromise their safety. This exam is not a substitute for care provided by your own healthcare
provider, and this exam does not establish a healthcare provider/patient relationship.

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).

Today’s date: ___________________________ OMC Patient ID (if known): ___________________________

Name: __________________________________________________________________________ Date of birth: ___________________________

Height: _____ ft. _____ in.  Weight: _____ lbs.

Employer: __________________________________________________________________________

Job title: __________________________________________________________________________ Length of employment: ___________________________

Age (to nearest year): _____  Sex:  ☐ Male  ☐ Female

A phone number where you can be reached by the healthcare professional who reviews this questionnaire
(include the Area Code): __________________________________________________________________________

Best time to contact you at this number: __________________________________________________________________________

Has your employer told you how to contact the healthcare professional who will review
this questionnaire?  ☐ Yes  ☐ No

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 (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained
breathing apparatus).

Have you worn a respirator?  ☐ 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 check "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?  ☐ Yes  ☐ No
   a. How many years have you smoked? ______
   b. How many packs of cigarettes do you smoke per day? ______

2. Have you ever had any of the following conditions:
   c. Seizures (fits)?  ☐ Yes  ☐ No
d. Diabetes (sugar disease)?  ☐ Yes  ☐ No
e. Allergic reactions that interfere with your breathing?  ☐ Yes  ☐ No
f. Claustrophobia (fear of closed-in places)?  ☐ Yes  ☐ No
g. Trouble smelling odors (except when you had a cold)?  ☐ Yes  ☐ No

3. Have you ever had any of the following pulmonary or lung problems:
a. Asbestos?  ☐ 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. Any other lung problem that you’ve been told about? □ Yes □ No

4. Do you currently have any of the following symptoms of pulmonary or lung disease:
   a. Shortness of breath? □ Yes □ No
   b. Shortness of breath when walking fast on level ground or walking up a slight hill/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 within 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? □ Yes □ No

5. Have you ever had any of the following cardiovascular or heart problems?
   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 (heart beating irregularly)? □ Yes □ No
g. High blood pressure? □ Yes □ No
h. Any other heart problems you have been told about? □ Yes □ No

6. Have you ever had any of the following cardiovascular or heart problems:
   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 gastrointestinal disease? □ Yes □ No
g. Any other symptoms that you think may be related to heart or circulation problems? □ Yes □ No

7. Do you currently take medications for any to the following problems:
   a. Breathing or lung problems? □ Yes □ No
   b. Heart problems? □ Yes □ No
c. Blood pressure? □ Yes □ No
d. Seizures (fits)? □ Yes □ No

List all medications that you are currently taking, including over-the-counter:
8. 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):
   a. Eye irritation?  
      [ ] Yes [ ] No
   b. Skin allergies or rashes?  
      [ ] Yes [ ] No
   c. Anxiety that occurs only when you use the respirator?  
      [ ] Yes [ ] No
   d. Unusual weakness or fatigue?  
      [ ] Yes [ ] No
   e. Any other problem that interferes with your use of a respirator?  
      [ ] Yes [ ] No

Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?  [ ] Yes  [ ] No

Questions 9 to 14  Every employee and/or applicant who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA) must answer the following questions. For employees who have been selected to use other types of respirators, answering these questions is voluntary.

9. Have you ever lost vision in either eye (temporarily or permanently)?  
   [ ] Yes  [ ] No

10. Do you currently have any of the following vision problems:
   a. Wear contact lenses?  
      [ ] Yes  [ ] No
   b. Wear glasses?  
      [ ] Yes  [ ] No
   c. Color blind?  
      [ ] Yes  [ ] No
   d. Any other eye or vision problem?  
      [ ] Yes  [ ] No

11. Have you ever had an injury to your ears, including a broken ear drum?  
    [ ] Yes  [ ] No

12. Do you currently have any of the following hearing problems:
    a. Difficulty hearing?  
       [ ] Yes  [ ] No
    b. Wearing a hearing aid?  
       [ ] Yes  [ ] No
    c. Any other hearing or ear problem?  
       [ ] Yes  [ ] No

13. Have you ever had a back injury?  
    [ ] Yes  [ ] No

14. Do you currently have any of the following musculoskeletal problems:
    a. Weakness in any of your arms, hands, legs, or feet?  
       [ ] Yes  [ ] No
    b. Back pain?  
       [ ] Yes  [ ] No
    c. Difficulty fully moving your arms and 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 your knees?  
       [ ] Yes  [ ] No
    h. Difficulty squatting to the ground?  
       [ ] Yes  [ ] No
    i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.?  
       [ ] Yes  [ ] No
    j. Any other muscle or skeletal problem that interferes with using a respirator?  
       [ ] Yes  [ ] No

Please explain all “Yes” responses to questions 1-14:

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Every employee and/or applicant who has been selected to use a self-contained breathing apparatus (SCBA) must answer the following questions in Part B.
Part B: Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the healthcare professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?  
   □ Yes □ No  
   If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions?  
   □ Yes □ No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?  
   □ Yes □ No  
   If "yes," name the chemicals if you know them: __________________________________________  
   __________________________________________

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:  
   a. Asbestos?  
      □ Yes □ No  
   b. Silica (e.g., in sandblasting)?  
      □ Yes □ No  
   c. Tungsten/cobalt (e.g., grinding or welding this material)?  
      □ Yes □ No  
   d. Beryllium?  
      □ Yes □ No  
   e. Aluminum?  
      □ Yes □ No  
   f. Coal (for example, mining)?  
      □ Yes □ No  
   g. Iron?  
      □ Yes □ No  
   h. Tin?  
      □ Yes □ No  
   i. Dusty environments?  
      □ Yes □ No  
   j. Any other hazardous exposures?  
      □ Yes □ No  
      If "yes," describe these exposures: __________________________________________  
      __________________________________________

4. List any second jobs or side businesses you have: __________________________________________  
   __________________________________________

5. List your previous occupations: __________________________________________

6. List your current and previous hobbies: __________________________________________

7. Have you been in the military services?  
   □ Yes □ No  
   If "yes," were you exposed to biological or chemical agents (either in training or combat)?  
   □ Yes □ No

8. Have you ever worked on a HAZMAT team?  
   □ Yes □ No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)?  
   □ Yes □ No  
   If "yes," name the medications if you know them: __________________________________________
10. Will you be using any of the following items with your respirator(s):
   a. HEPA Filters? □ Yes □ No
   b. Canisters (for example, gas masks)? □ Yes □ No
   c. Cartridges? □ Yes □ No

11. How often are you expected to use the respirator(s)? Check "yes" or "no" for all answers that apply to you.
   a. Escape only (no rescue)? □ Yes □ No
   b. Emergency rescue only? □ Yes □ No
   c. Less than 5 hours per week? □ Yes □ No
   d. Less than 2 hours per day? □ Yes □ No
   e. 2 to 4 hours per day? □ Yes □ No
   f. Over 4 hours per day? □ Yes □ No

12. During the period you are using the respirator(s), is your work effort:
   a. Light (less than 200 kcal per hour)? □ Yes □ No
      If "yes," how long does this period last during the average shift? _____ hrs. _____ mins.
      Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.
   b. Moderate (200 to 350 kcal per hour)? □ Yes □ No
      If "yes," how long does this period last during the average shift? _____ hrs. _____ mins.
      Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
   c. Heavy (above 350 kcal per hour)? □ Yes □ No
      If "yes," how long does this period last during the average shift? _____ hrs. _____ mins.
      Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? □ Yes □ No
   If "yes," describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperature exceeding 77 deg. F)? □ Yes □ No
15. Will you be working under humid conditions? □ Yes □ No

16. Describe the work you'll be doing while you're using your respirator(s).

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s), (for example, confined spaces, life-threatening gases).
18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s).

Name of the first toxic substance: ____________________________
Estimated maximum exposure level per shift: ____________________________
Duration of exposure per shift: ____________________________
Name of the second toxic substance: ____________________________
Estimated maximum exposure level per shift: ____________________________
Duration of exposure per shift: ____________________________
Name of the third toxic substance: ____________________________
Estimated maximum exposure level per shift: ____________________________
Duration of exposure per shift: ____________________________

The name of any other toxic substances that you'll be exposed to while using your respirator:
________________________________________________________________________
________________________________________________________________________

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security).
________________________________________________________________________
________________________________________________________________________