



# Respiratory and Asbestos Questionnaire for Occupational Health Services

For a qualified healthcare provider to properly assess the ability of an employee/applicant to wear a respirator, a medical history must be known. This questionnaire will aid in that regard. Please fill out this questionnaire as accurately as possible.

Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Today's date: \_\_\_\_\_

Employer: \_\_\_\_\_

Job title: \_\_\_\_\_ Length of employment: \_\_\_\_\_

Age (to nearest year): \_\_\_\_\_ Sex:  Male  Female

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): \_\_\_\_\_



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:
  - a. Seizures (fits)?  Yes  No
  - b. Diabetes (sugar disease)?  Yes  No
  - c. Allergic reactions that interfere with your breathing?  Yes  No
  - d. Claustrophobia (fear of closed-in places)?  Yes  No
  - e. 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:**

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8. If you have ever worn a respirator, has it caused any of the following problems:
- 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

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:

Question Number	Explanation





18. PAST MEDICAL HISTORY

- |                                                           | YES   | NO    |
|-----------------------------------------------------------|-------|-------|
| A. Do you consider yourself to be in good health?         | _____ | _____ |
| If "NO" state reason _____                                |       |       |
| B. Have you any defect of vision? .....                   | _____ | _____ |
| If "YES" state nature of defect _____                     |       |       |
| C. Have you any hearing defect? .....                     | _____ | _____ |
| If "YES" state nature of defect _____                     |       |       |
| D. Are you suffering from or have you ever suffered from: |       |       |
|                                                           | YES   | NO    |
| a. Epilepsy (or fits, seizures, convulsions)?             | _____ | _____ |
| b. Rheumatic fever?                                       | _____ | _____ |
| c. Kidney disease?                                        | _____ | _____ |
| d. Bladder disease?                                       | _____ | _____ |
| e. Diabetes?                                              | _____ | _____ |
| f. Jaundice?                                              | _____ | _____ |

19. CHEST COLDS AND CHEST ILLNESSES

19A. If you get a cold, does it "usually" go to your chest? (Usually means more than 1/2 the time)  
1. Yes \_\_\_ 2. No \_\_\_ 3. Don't get colds \_\_\_

20A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?  
1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 20A:

B. Did you produce phlegm with any of these chest illnesses?  
1. Yes \_\_\_ 2. No \_\_\_ 3. Does Not Apply \_\_\_

C. In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more?  
Number of illnesses \_\_\_ No such illnesses \_\_\_

21. Did you have any lung trouble before the age of 16?  
1. Yes \_\_\_ 2. No \_\_\_

22. Have you ever had any of the following?

1A. Attacks of bronchitis? 1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 1A:

B. Was it confirmed by a doctor? 1. Yes \_\_\_ 2. No \_\_\_  
3. Does Not Apply \_\_\_

C. At what age was your first attack? Age in Years \_\_\_  
Does Not Apply \_\_\_

2A. Pneumonia (include bronchopneumonia)? 1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 2A:

B. Was it confirmed by a doctor? 1. Yes \_\_\_ 2. No \_\_\_ 3. Does Not Apply \_\_\_

C. At what age did you first have it? Age in Years \_\_\_ Does Not Apply \_\_\_

3A. Hay Fever? 1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 3A:

B. Was it confirmed by a doctor? 1. Yes \_\_\_ 2. No \_\_\_ 3. Does Not Apply \_\_\_

C. At what age did it start? Age in Years \_\_\_  
Does Not Apply \_\_\_

23A. Have you ever had chronic bronchitis? 1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 23A:

B. Do you still have it? 1. Yes \_\_\_ 2. No \_\_\_  
3. Does Not Apply \_\_\_

C. Was it confirmed by a doctor? 1. Yes \_\_\_ 2. No \_\_\_  
3. Does Not Apply \_\_\_

D. At what age did it start? Age in Years \_\_\_  
Does Not Apply \_\_\_

24A. Have you ever had emphysema? 1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 24A:

B. Do you still have it? 1. Yes \_\_\_ 2. No \_\_\_  
3. Does Not Apply \_\_\_

C. Was it confirmed by a doctor? 1. Yes \_\_\_ 2. No \_\_\_  
3. Does Not Apply \_\_\_

D. At what age did it start? Age in Years \_\_\_  
Does Not Apply \_\_\_

25A. Have you ever had asthma? 1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 25A:

B. Do you still have it? 1. Yes \_\_\_ 2. No \_\_\_  
3. Does Not Apply \_\_\_

C. Was it confirmed by a doctor? 1. Yes \_\_\_ 2. No \_\_\_  
3. Does Not Apply \_\_\_

D. At what age did it start? Age in Years \_\_\_  
Does Not Apply \_\_\_

E. If you no longer have it, at what age did it stop?  
Age stopped \_\_\_  
Does Not Apply \_\_\_

26. Have you ever had:

A. Any other chest illness? 1. Yes \_\_\_ 2. No \_\_\_

If yes, please specify \_\_\_\_\_

B. Any chest operations? 1. Yes \_\_\_ 2. No \_\_\_

If yes, please specify \_\_\_\_\_

C. Any chest injuries? 1. Yes \_\_\_ 2. No \_\_\_

If yes, please specify \_\_\_\_\_

27A. Has a doctor ever told you that you had heart trouble?  
1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 27A:

B. Have you ever had treatment for heart trouble in the past 10 years?  
1. Yes \_\_\_ 2. No \_\_\_  
3. Does Not Apply \_\_\_

28A. Has a doctor told you that you had high blood pressure?  
1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 28A:

B. Have you had any treatment for high blood pressure (hypertension) in the past 10 years?  
1. Yes \_\_\_ 2. No \_\_\_  
3. Does Not Apply \_\_\_

29. When did you last have your chest X-rayed?  
(Year) \_\_\_ \_\_\_ \_\_\_ \_\_\_

30. Where did you last have your chest X-rayed (if known)?  
\_\_\_\_\_  
What was the outcome? \_\_\_\_\_

**FAMILY HISTORY**

31. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

	FATHER			MOTHER		
	1. Yes	2. No	3. Don't know	1. Yes	2. No	3. Don't know
A. Chronic Bronchitis?	___	___	___	___	___	___
B. Emphysema?	___	___	___	___	___	___
C. Asthma?	___	___	___	___	___	___
D. Lung cancer?	___	___	___	___	___	___
E. Other chest conditions?	___	___	___	___	___	___
F. Is parent currently alive?	___	___	___	___	___	___
G. Please Specify	___	Age if Living		___	Age if Living	
	___	Age at Death		___	Age at Death	
	___	Don't Know		___	Don't Know	

H. Please specify cause of death \_\_\_\_\_

COUGH

32A. Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.) (If no, skip to question 32C.)

1. Yes \_\_\_ 2. No \_\_\_

B. Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week?

1. Yes \_\_\_ 2. No \_\_\_

C. Do you usually cough at all on getting up or first thing in the morning?

1. Yes \_\_\_ 2. No \_\_\_

D. Do you usually cough at all during the rest of the day or at night?

1. Yes \_\_\_ 2. No \_\_\_

IF YES TO ANY OF ABOVE (32A, B, C, OR D), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO NEXT PAGE

E. Do you usually cough like this on most days for 3 consecutive months or more during the year?

1. Yes \_\_\_ 2. No \_\_\_ 3. Does not apply \_\_\_

F. For how many years have you had the cough?      Number of years \_\_\_  
Does not apply \_\_\_

33A. Do you usually bring up phlegm from your chest?  
(Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) (If no, skip to 33C)

1. Yes \_\_\_ 2. No \_\_\_

B. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week?

1. Yes \_\_\_ 2. No \_\_\_

C. Do you usually bring up phlegm at all on getting up or first thing in the morning?

1. Yes \_\_\_ 2. No \_\_\_

D. Do you usually bring up phlegm at all on during the rest of the day or at night?

1. Yes \_\_\_ 2. No \_\_\_

IF YES TO ANY OF THE ABOVE (33A, B, C, OR D), ANSWER THE FOLLOWING:

IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO 34A

E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?

1. Yes \_\_\_ 2. No \_\_\_ 3. Does not apply \_\_\_

F. For how many years have you had trouble with phlegm?

Number of years \_\_\_  
Does not apply \_\_\_

EPISODES OF COUGH AND PHLEGM

34A. Have you had periods or episodes of (increased\*) cough and phlegm lasting for 3 weeks or more each year? \*(For persons who usually have cough and/or phlegm)

1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 34A

B. For how long have you had at least 1 such episode per year?

Number of years \_\_\_

Does not apply \_\_\_

#### WHEEZING

35A. Does your chest ever sound wheezy or whistling

1. When you have a cold? 1. Yes \_\_\_ 2. No \_\_\_

2. Occasionally apart from colds? 1. Yes \_\_\_ 2. No \_\_\_

3. Most days or nights? 1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 1, 2, or 3 in 35A

B. For how many years has this been present?

Number of years \_\_\_

Does not apply \_\_\_

36A. Have you ever had an attack of wheezing that has made you feel short of breath?

1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 36A

B. How old were you when you had your first such attack?

Age in years \_\_\_

Does not apply \_\_\_

C. Have you had 2 or more such episodes?

1. Yes \_\_\_ 2. No \_\_\_

3. Does not apply \_\_\_

D. Have you ever required medicine or treatment for the(se) attack(s)?

1. Yes \_\_\_ 2. No \_\_\_

3. Does not apply \_\_\_

#### BREATHLESSNESS

37. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 39A.

Nature of condition(s) \_\_\_\_\_  
\_\_\_\_\_

38A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 38A

B. Do you have to walk slower than people of your age on the level because of breathlessness?

1. Yes \_\_\_ 2. No \_\_\_

3. Does not apply \_\_\_

C. Do you ever have to stop for breath when walking at your own pace on the level?

1. Yes \_\_\_ 2. No \_\_\_  
3. Does not apply \_\_\_

D. Do you ever have to stop for breath after walking about 100 yards  
(or after a few minutes) on the level?

1. Yes \_\_\_ 2. No \_\_\_ 3. Does not apply \_\_\_

E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs?

1. Yes \_\_\_ 2. No \_\_\_ 3. Does not apply \_\_\_

#### TOBACCO SMOKING

39A. Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or  
12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year.)

1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 39A

B. Do you now smoke cigarettes (as of one month ago)

1. Yes \_\_\_ 2. No \_\_\_  
3. Does not apply \_\_\_

C. How old were you when you first started regular cigarette smoking?

Age in years \_\_\_  
Does not apply \_\_\_

D. If you have stopped smoking cigarettes completely, how old were you when you stopped?

Age stopped \_\_\_  
Check if still smoking \_\_\_  
Does not apply \_\_\_

E. How many cigarettes do you smoke per day now?

Cigarettes per day \_\_\_  
Does not apply \_\_\_

F. On the average of the entire time you smoked, how many cigarettes did you smoke per day?

Cigarettes per day \_\_\_  
Does not apply \_\_\_

G. Do or did you inhale the cigarette smoke?

1. Does not apply \_\_\_  
2. Not at all \_\_\_  
3. Slightly \_\_\_  
4. Moderately \_\_\_  
5. Deeply \_\_\_

40A. Have you ever smoked a pipe regularly?  
(Yes means more than 12 oz. of tobacco in a lifetime.)

1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 40A:

FOR PERSONS WHO HAVE EVER SMOKED A PIPE

B. 1. How old were you when you started to smoke a pipe regularly?

Age \_\_\_

2. If you have stopped smoking a pipe completely, how old were you when you stopped?

Age stopped \_\_\_  
Check if still smoking pipe \_\_\_  
Does not apply \_\_\_

C. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week?  
\_\_\_\_\_ oz. per week (a standard pouch of tobacco contains 1 1/2 oz.)  
\_\_\_\_\_ Does not apply

D. How much pipe tobacco are you smoking now?  
oz. per week \_\_\_\_\_  
Not currently smoking a pipe \_\_\_\_\_

E. Do you or did you inhale the pipe smoke?  
1. Never smoked \_\_\_\_\_  
2. Not at all \_\_\_\_\_  
3. Slightly \_\_\_\_\_  
4. Moderately \_\_\_\_\_  
5. Deeply \_\_\_\_\_

41A. Have you ever smoked cigars regularly?  
1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_  
(Yes means more than 1 cigar a week for a year)

IF YES TO 41A

FOR PERSONS WHO HAVE EVER SMOKED A PIPE

- B. 1. How old were you when you started smoking cigars regularly? Age \_\_\_\_\_
2. If you have stopped smoking cigars completely, how old were you when you stopped. Age stopped \_\_\_\_\_  
Check if still smoking cigars \_\_\_\_\_  
Does not apply \_\_\_\_\_
- C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week? Cigars per week \_\_\_\_\_  
Does not apply \_\_\_\_\_
- D. How many cigars are you smoking per week now? Cigars per week \_\_\_\_\_  
Check if not smoking cigars currently \_\_\_\_\_
- E. Do or did you inhale the cigar smoke?  
1. Never smoked \_\_\_\_\_  
2. Not at all \_\_\_\_\_  
3. Slightly \_\_\_\_\_  
4. Moderately \_\_\_\_\_  
5. Deeply \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_