MAYO CLINIC
HEALTH SYSTEM

Respirator Questionnaire

Cannon Falls
Lake City
Red Wing

This form collects information that is part of the medical record. **Route to Scanning.**

MRN Number: ______________________

Can you read? ☐ Yes ☐ No	Date Today *(Month DD, YYYY)*	Birth Date *(Month DD, YYYY)*	Sex ☐ Male ☐ Female
Name *(First, Middle, Last)*		Social Security Number	
Phone		Best Time to Call ____________ AM PM	
Address *(Street)*			
City		State	ZIP Code
Name of Company Requesting This Exam		Job Title/Department	

Please complete all sections of this form that apply to you and sign the certifying statement on the last page.

HAVE YOU HAD ANY SIGNIFICANT CHANGE IN YOUR HEALTH SINCE YOUR LAST RESPIRATOR EXAMINATION? ☐ **YES** ☐ **NO**

RESPIRATOR USE INFORMATION – Mandatory for all users (29 CFR 1910.134, Part A, Section 1)

TYPE ***(Check all types used or to be used)***

_____Disposable dust mask (N, R, or P)
_____Air purifying respirator (Cartridge)
_____Positive pressure air-line
_____Powered air purifying
_____Self-contained breathing apparatus (SCBA)
_____HazMat protective clothing
_____Other (list): ____________________
____

Weight of respirator ____________________
Weight of other protective equipment __________

POTENTIAL EXPOSURE ***(Check all that apply)***

_____Nuisance dust
_____Solvents/petroleum/paints
_____Acids/Bases
_____IDLH immediate hazards
_____Metal dust/fumes
_____Biological agents (TB, etc)
_____Hot humid conditions
_____Asbestos ________________________
_____Other (list):________________________
____

LEVEL OF WORK EFFORT WITH PROTECTIVE EQUIPMENT ***(Check one)***

_____Light (typing, light assembly, etc)
_____Medium(pushing wheelbarrow, nailing)
_____Heavy(lifting over 50 lbs, shoveling)
_____Strenuous (Emergency rescue)

EXTENT OF USE ***(Check one)***

_____Daily _____hours per day
_____Once per week or more
_____Once per month or more
_____Less than once per month
_____Emergency use only

Date last used____________________

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PART I: MEDICAL HISTORY – Mandatory for all users (29 CFR 1910.134, Part A, Section 2)

Questions 1 through 9 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?
☐	☐	b. Diabetes (sugar disease)?
☐	☐	c. Allergic reactions that interfere with your breathing?
☐	☐	d. Claustrophobia (fear of closed-in places)?
☐	☐	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. Pnuemothorax (collapsed lung)?
☐	☐	i. Lung Cancer?
☐	☐	j. Broken Ribs?
☐	☐	k. Any chest injuries or surgeries?
☐	☐	l. Any other lung problems that you've been told about?
		4. Do you currently have any of the following symptoms of pulmonary or lung illness?
☐	☐	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?
☐	☐	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 your job?
☐	☐	m. Chest pain when you breathe deeply?
☐	☐	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?
☐	☐	a. Heart attack?
☐	☐	b. Stroke?
☐	☐	c. Angina?
☐	☐	d. Heart failure?
☐	☐	e. Swelling in your legs or feet (not caused by walking)?
☐	☐	f. Hearth arrhythmia (heart beating irregularly)?
☐	☐	g. High blood pressure?
☐	☐	h. Any other heart problem that you've been told about?

YES	NO	
		6. Have you ever had any of the following cardiovascular or heart symptoms?
☐	☐	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 two 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?
☐	☐	a. Breathing or lung problems?
☐	☐	b. Heart trouble?
☐	☐	c. Blood Pressure?
☐	☐	d. Seizures?
		8. If you've used a respirator, have you ever had any of the following problems?
		(If you've never used a respirator check here ☐ and skip to section 9)
☐	☐	a. Eye irritation?
☐	☐	b. Skin allergies or rashes?
☐	☐	c. Anxiety?
☐	☐	d. General weakness or fatique?
☐	☐	e. Any other problems that interferes with your use of a respirator?
☐	☐	**9. Would you like to talk to the health care professional who will review your answers to this questionnaire?**

PART II: MEDICAL HISTORY – Mandatory for all users (29 DFR 1910.134, Part A, Section 2)

Questions 10-15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

YES	NO	
☐	☐	**10. Have you ever lost vision in either eye (temporarily or permanently)?**
		11. Do you currently have any of the following vision problems?
☐	☐	a. Wear contact lenses?
☐	☐	b. Wear glasses?
☐	☐	c. Color Blind?
☐	☐	d. Any other eye or vision problem?
☐	☐	**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? *(check all that apply)*
☐	☐	a. Weakness in any of your arms, hands, legs or feet?
☐	☐	b. Back pain?
☐	☐	c. Difficulty fully moving your arms and legs?
☐	☐	d. Pain/stiffness when you lean forward/backward at the waist?
☐	☐	e. Difficulties fully moving your head up or down?
☐	☐	f. Difficulty fully moving your head side to side?
☐	☐	g. Difficulty bending at your knees?
☐	☐	h. Difficulty squatting to the ground?
☐	☐	i. Climbing a flight of stairs or a ladder carrying more than 25lbs?
☐	☐	j. Any other muscle or skeletal problem that interferes with using a respirator?

PART III – MEDICAL HISTORY – Voluntary for users of all types of respirators.

YES	NO	
☐	☐	**16. Have you been exposed to any accidents/spills/exposures since your last exam?**
☐	☐	**17. Have you had any job changes or new exposures since your last exam?**
☐	☐	**18. Do you have physical symptoms or medical problems that you believe are related to your job? If yes:**
☐	☐	a. Do symptoms occur in any pattern at work, such as time, place or processes?
☐	☐	b. Are symptoms affected by time off such as vacations or weekends?
☐	☐	c. Are symptoms affected by the use of personal protective equipment?
☐	☐	d. Have symptoms been medically evaluated?
☐	☐	**19. Do you have a sore or burning nose or throat at work?**
☐	☐	**20. Do you have trouble concentrating or remembering?**
☐	☐	**21. Have any of your co-workers experienced health problems connected to this job?**
☐	☐	**22. Can you smell any chemicals while using your respirator?**
☐	☐	**23. Have you had teeth extracted within the past year?**
☐	☐	**24. Have you gained or lost weight in the last year?**
		25. Have you experienced any of the following within the past five years?
☐	☐	a. Heat stroke?
☐	☐	b. Heat intolerance?
☐	☐	c. Allergy to natural latex rubber?
☐	☐	d. Excessive daytime drowsiness?
☐	☐	e. Severe snoring or sleep apnea?
☐	☐	f. Any other medical condition?
☐	☐	g. Dizziness or lightheadedness at work?
☐	☐	h. Hobbies that create dust or fumes?

WORK HISTORY – List your jobs, starting with the most recent. Include military service.

Company	Job Title(s)	Number of Months/Years
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

Have you ever worked, or do you work in or with:

☐ Foundry ☐ Sandblasting ☐ Mine ☐ Quarry ☐ Other______________________

☐ Asbestos ☐ Dust ☐ Fumes,Chemicals ☐ Textile Mill ______________________

If yes, when? ________________________________ How long? ______________________________

Do you have a second job or side business? ☐ Yes ☐ No If yes, what? ______________________________

Have you worn a respirator in the past? ☐ Yes ☐ No

Date of your last physical exam ______________________ Height ____________ Present Weight __________

EMPLOYEE STATEMENT CERTIFYING ACCURACY OF INFORMATION

I certify that my answers to the questions on this history form are true and accurate. I am aware that this information will be used by the medical provider in making a determination of my ability to wear a respirator while performing my current job.

Signature	Date
Medical Review	Date