MAYO CLINIC HEALTH SYSTEM

Respirator Questionnaire

Location: ☐ Albert Lea ☐ Austin ☐ Cannon Falls ☐ Faribault ☐ Lake City ☐ Owatonna ☐ Red Wing

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

Can you read? ☐ Yes ☐ No

Instructions: Complete all sections of this form that apply to you and sign the certifying statement on the last page.

Patient Information

Medical Record Number	Name *(First, Middle, Last)*		Birth Date *(Month DD, YYYY)*	
Sex ☐ Male ☐ Female	Date Today *(Month DD, YYYY)*	Phone – –	Best Time to Call ☐ a.m. ☐ p.m.	
Street Address		City	State	ZIP Code
Company Requesting Exam		Job Title	Department	

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: _____

  _____

Respirator weight: _____

Other protective equipment weight: _____

Potential Exposure *(check all that apply)*

- ☐ Nuisance dust
- ☐ Solvents/petroleums/paints
- ☐ Acids/bases
- ☐ IDLH immediate hazards
- ☐ Metal dust/fumes
- ☐ Biological agents (TB, etc.)
- ☐ Hot, humid conditions
- ☐ Asbestos
- ☐ Other: _____

  _____

Work Effort Level With Protective Equipment *(check one)*

- ☐ Light (typing, light assembly, etc.)
- ☐ Medium (pushing wheelbarrow, nailing)
- ☐ Heavy (lifting over 50 pounds, shoveling)
- ☐ Strenuous (emergency rescue)

Extent Used *(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 *(Month DD, YYYY)* _____

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Medical Record Number	Name *(First, Middle, Last)*

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 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 (collapsed lung)
☐	☐	i. Lung cancer
☐	☐	j. Broken ribs
☐	☐	k. Chest injuries or surgeries
☐	☐	l. Other lung problems
		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. Other symptoms 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. Heart arrhythmia (heart beating irregularly)
☐	☐	g. High blood pressure
☐	☐	h. Other heart problem

Medical Record Number	Name *(First, Middle, Last)*

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, you've noticed your heart skipping or missing a beat
☐	☐	e. Heartburn or indigestion that is not related to eating
☐	☐	f. 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. Have you ever used a respirator? If no, skip to question 9. If yes, have you ever had any of the following problems?
☐	☐	a. Eye irritation
☐	☐	b. Skin allergies or rashes
☐	☐	c. Anxiety
☐	☐	d. General weakness or fatigue
☐	☐	e. Other problems that interfere 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 through 15 below must be answered by every employee who has been selected to use either a full face-piece 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. 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. 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 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. 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 while carrying more than 25 pounds
☐	☐	j. Other muscle or skeletal problem that interferes with using a respirator

Medical Record Number	Name *(First, Middle, Last)*

Part III: Medical History – Voluntary for users of all types of respirators.

Yes	No		
☐	☐	16.	Have you been exposed to any accidents, spills, or 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 no, skip to question 19. If yes, do any of the following apply to your symptoms?
☐	☐		a. Symptoms occur in a pattern at work, such as time, place or processes
☐	☐		b. Symptoms are affected by time off, such as vacations or weekends
☐	☐		c. Symptoms are affected by the use of personal protective equipment
☐	☐		d. Symptoms have 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 coworkers 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. 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)	Employment Duration *(months or years)*

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

☐ Asbestos ☐ Dust ☐ Foundry ☐ Fumes, Chemicals ☐ Other _____

☐ Mine ☐ Quarry ☐ Sandblasting ☐ Textile Mill _____

If yes, when? _____ For how long? _____

Do you have a second job or side business? ☐ Yes ☐ No

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

Last physical exam date *(Month DD, YYYY)* _____ Height _____ Present Weight _____

Employee Statement

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 at my current job.

Employee Signature	Date *(Month DD, YYYY)*
Medical Reviewer Signature	Date *(Month DD, YYYY)*