Your Hospital's Logo Here

RESPIRATOR USE
OCCUPATIONAL SURVEILLANCE

Please complete this confidential questionnaire by placing a check mark in the appropriate spaces or by printing other information when required . (Use black or blue ink).

IDENTIFICATION

TODAY'S DATE:	LAST NAME:	FIRST (No nicknames)		MIDDLE
SEX: ☐ MALE ☐ FEMALE	SOCIAL SECURITY NO: - -			BIRTHDATE: - -
AGENCY / DEPT:		BLDG / ROOM		BUSINESS PHONE:
JOB TITLE:		SUPERVISOR		SUPERVISOR'S PHONE:
YOUR MAILING ADDRESS:		CITY / STATE	ZIP	HOME PHONE:

MEDICATIONS

List **ALL** medications (including prescription, vitamins, and herbal preparations) you currently take:

HOSPITALIZATIONS & SURGERIES

List **ALL** hospitalizations, surgeries, and the years they occurred:

PAST MEDICAL HISTORY

Check any of the following conditions that you have now or have ever had:

EAR:

Condition			Condition		
DECREASED HEARING	☐ YES	☐ NO	OTHER EAR INJURY	☐ YES	☐ NO
HEARING LOSS	☐ YES	☐ NO	OTHER (Explain):		

HEART:

Condition			Condition		
CHEST PAIN / TIGHTNESS	☐ YES	☐ NO	Non Eating Related HEARTBURN / INDIGESTION	☐ YES	☐ NO
CONGESTIVE HEART FAILURE	☐ YES	☐ NO	IRREGULAR HEART BEAT	☐ YES	☐ NO
HEART MURMUR	☐ YES	☐ NO	SWELLING OF LEGS / FEET	☐ YES	☐ NO
HEART ATTACK	☐ YES	☐ NO	STROKE	☐ YES	☐ NO
HIGH BLOOD PRESSURE	☐ YES	☐ NO	OTHER (Explain):		

LUNG:

Condition			Condition		
ASBESTOSIS	☐ YES	☐ NO	PNEUMOTHORAX (COLLAPSED LUNG)	☐ YES	☐ NO
CHRONIC BRONCHITIS	☐ YES	☐ NO	COUGH producing THICK PHLEGM	☐ YES	☐ NO
EMPHYSEMA	☐ YES	☐ NO	LUNG CANCER	☐ YES	☐ NO
PNEUMONIA	☐ YES	☐ NO	BROKEN RIBS	☐ YES	☐ NO
TUBERCULOSIS	☐ YES	☐ NO	ANY CHEST INJURIES / SURGERIES	☐ YES	☐ NO
SHORTNESS OF BREATH	☐ YES	☐ NO	COUGHING UP BLOOD	☐ YES	☐ NO
SILICOSIS	☐ YES	☐ NO	WHEEZING	☐ YES	☐ NO

OTHER:

Condition			Condition		
EYE IRRITATION	☐ YES	☐ NO	GENERAL WEAKNESS	☐ YES	☐ NO
SKIN ALLERGIES / RASHES	☐ YES	☐ NO	CLAUSTROPHOBIA	☐ YES	☐ NO
SEIZURES	☐ YES	☐ NO	OTHER (Explain):		
ANXIETY	☐ YES	☐ NO	OTHER (Explain):		

RESPIRATOR QUESTIONNAIRE

Question				
Indicate the type of respirator you use:	☐ Cartridge	☐ Air Supply	☐ SCBA	☐ Filter / Mask
How often do you use a respirator?	☐ Daily	☐ 1x-4x per Week	☐ 1x-4x per Month	☐ 1x-4x per Year
Hours of use in a typical day:	☐ < 2 Hours	☐ 2-4 Hours	☐ 4-6 Hours	☐ > 6 Hours
Usual effort while wearing respirator?	☐ Light	☐ Moderate	☐ Heavy	
Hazards present during respirator use:	☐ High Altitude	☐ Temperature Extremes	☐ Confined Spaces	

Question		
Wear contact lenses?	☐ Y	☐ N
Previous respirator use?	☐ Y	☐ N
Difficulty with previous respirator use?	☐ Y	☐ N
Wear glasses?	☐ Y	☐ N

SOCIAL HISTORY:

(1) Have you ever used tobacco? ☐ YES ☐ NO

(a) If "YES", when? ☐ CURRENT ☐ PAST (Years since quitting?) ________

(b) If "YES", what type? ☐ CIGARETTES ☐ PIPE / CIGAR

________ Amount Per Day ________ For How Many Years

(2) What is your average alcohol consumption in a week? ________ Drinks (1 drink = 12 oz. Beer, 1 Glass Wine or 1.5 Oz. Liquor)

(3) How often do you drink alcohol? ☐ WEEKDAYS ☐ WEEKENDS ☐ BOTH

(4) Have you ever worked with any materials -or- under any conditions listed below: *(Check all that apply & describe items checked)*

- ☐ ASBESTOS
- ☐ SILICA (in sandblasting)
- ☐ TUNGSTEN / COBALT (grinding / welding this material)
- ☐ BERYLLIUM
- ☐ ALUMINUM
- ☐ COAL (in mining, etc.)
- ☐ IRON
- ☐ TIN
- ☐ DUSTY ENVIRONMENTS
- ☐ ANY OTHER HAZARDOUS EXPOSURES (List Below)

PFT: ☐ DONE ☐ NOT DONE

HEIGHT:	WEIGHT:	TEMP:	RESP:	BP:	PULSE:

DRUG ALLERGY:	GENERAL HEALTH:

	Normal	Abnormal	Not Done	Findings
E.E.N.T.	☐	☐	☐	
Heart	☐	☐	☐	
Lungs	☐	☐	☐	
Extremities	☐	☐	☐	
Vascular-Pulses	☐	☐	☐	

ASSESSMENT / REFERRAL PLAN

	Comments	No Referral	Referred: Routine	Referred: Urgent
(1)		☐	☐	☐
		☐	☐	☐
(2)		☐	☐	☐
		☐	☐	☐
(3)		☐	☐	☐

RECOMMENDATIONS / EDUCATION SUMMARY

The following topics and recommendations marked with a 🗐 were discussed with the employee.

- ☐ Protective Equipment
  - ☐ Smoking cessation
  - ☐ Respirator use - fit test reminder
- ☐ Reduce or stop alcohol consumption
- ☐ Participate in regular post exposure screening, if necessary
- ☐ Other ________

EXAMINER'S SIGNATURE:	EXAMINER'S PRINTED NAME:	DATE:

EMPLOYEE'S SIGNATURE:	DATE:

I GIVE MY CONSENT FOR A PHYSICAL EXAMINATION THAT MAY INCLUDE TESTS & PROCEDURES DEEMED NECESSARY

EMPLOYEE'S SIGNATURE:	DATE: