ECHN CorpCare
Occupational Health

2800 Tamarack Ave Suite 001
South Windsor, CT 06074
Phone 860-647-4796 Fax 860-644-0287

Evaluation for Respirator Use

Can you read? (Check one): [ ] YES [ ]NO

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 CorpCare health professional who will review it.

Part A

The following information must be provided by every employee who has been selected to use any type of respirator. Please print.

1. Today's date: _____
2. Your name: _____
3. Your age (to nearest year): _____ years
4. Sex (check one): [ ]Male [ ]Female
5. Your height: _____feet _____inches
6. Your weight: _____pounds
7. Your job title: _____
8. A telephone number where you can be reached by a CorpCare health professional who will review this questionnaire (include area code): _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact a CorpCare health professional who will review this questionnaire? (Check one): [ ]YES [ ]NO
11. Check the type of respirator you will use (you may check more than one category):
    a. [ ]N, R, or P disposable respirator (filter-mask, non-cartridge type)

Examples →

Disposable filter-mask, "dust mask"

    b. [ ]Other type (for example, half or full-face piece type, powered-air purifying, supplied air, self-contained breathing apparatus).

Examples →

Half-face Respirator

Self-contained Breathing Apparatus

12. Have you worn a respirator? (Check one): [ ]YES [ ]NO
    If YES, what type(s): _____

Reviewed/Date: _____

This questionnaire is required by OSHA standard 29 CFR 1910.134, Appendix C

Evaluation for Respirator Use

Questions 1 through 9 must be answered by every employee who has been selected to use any type of respirator. Please check "YES" or "NO".

1. Have you ever smoked? [ ] YES [ ] NO If YES, how old were you when you started? ____ Years old
   Stopped? ____ Years old
   How many packs of cigarettes do/did you smoke per day? _____ Packs/day
   Cigars per day? _____ /day
   Do you currently smoke, or have you smoked in the past 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. Heat exhaustion/stroke….. [ ] YES [ ] NO
   d. Loss of consciousness…...[ ]YES [ ]NO
   e. Allergic reactions that interfere with your breathing…[ ]YES [ ]NO
   f. Claustrophobia (fear of closed in places)……..……[ ]YES [ ]NO
   g. Allergy to latex or rubber……...[ ]YES [ ]NO

3. Have you *ever* had any of the following pulmonary or lung problems?
   a. Asbestosis…… [ ]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: ……...[ ]YES [ ]NO
   i. Lung cancer: …….. [ ]YES [ ]NO
   j. Broken ribs: ……[ ]YES [ ]NO
   k. Any chest injuries or surgeries: ……..[ ]YES [ ]NO
   l. Any other lung problems……...[ ]YES [ ]NO

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath…….. [ ]YES [ ]NO
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or 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 in the past 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
   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 problem 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…… [ ]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 other symptoms that you think may be related to heart or circulation problems…… [ ]YES [ ]NO

Evaluation for Respirator Use

7. Do you currently take medication for any of the following problems?
   a. Breathing or lung problems…… [ ] YES [ ] NO c. Blood pressure……. [ ]YES [ ]NO
   b. Heart trouble…….. [ ] YES [ ] NO d. Seizures…… [ ]YES [ ]NO

   Please list any medication your are taking, including over-the-counter medication: _____
   _____

8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check the following space → |__|(I have never used a respirator), and go to question 9.
   a. Eye irritation……..[ ]YES [ ]NO d. Anxiety…….…….. [ ]YES [ ]NO
   b. Skin allergies or rashes……..[ ]YES [ ]NO e. General weakness or fatigue……. [ ]YES [ ]NO
   c. Any other problem that interferes with your use of a respirator…… [ ]YES [ ]NO

9. Would you like to talk to a CorpCare health professional about your answers to this questionnaire?
   [ ]YES [ ]NO

The following questions 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.

10. Have you ever lost vision in either eye (temporarily or permanent)? ……. [ ]YES [ ]NO

11. Do you currently have any of the following vision problems?
    a. Wear contact lenses ……..[ ]YES [ ]NO c. Color blind……..…[ ]YES [ ]NO
    b. Wear glasses…… …….. [ ]YES [ ]NO d. Any other eye or vision problem……..[ ]YES [ ]NO

12. Have you ever had an injury to your ears, including a broken ear drum…….…..[ ]YES [ ]NO

13. Do your 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

14. Have you ever had a back injury…….. [ ]YES [ ]NO

15. 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. Climbing a flight of stairs or a ladder carrying more than 25 pounds……..... [ ]YES [ ]NO
    j. Any other muscle or skeletal problem that interferes with using a respirator…… [ ]YES [ ]NO

Evaluation for Respirator Use

16. Please list any second jobs or side businesses: _____

17. How often are you expected to use the respirator(s)? (Check all that apply)
    a. [ ]..Escape only (no rescue)
    b. [ ]..Emergency rescue only
    c. [ ]..Less than 5 hours per week
    d. [ ]..Less than 2 hours per day
    e. [ ]..2 - 4 hours per day
    f. [ ]..Over 4 hours per day

18. During the period you are using the respirator(s), is your work effort:
    a. Light……..[ ]YES [ ]NO 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 pounds) or controlling machines.

    If YES, how long does this period last during the average work shift? ____hours and ____minutes

    b. Moderate...[ ]YES [ ]NO 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 pounds) at trunk level; walking on a level surface about 2 miles per hour or down a 5-degree grade about 3 miles per hour; or pushing a wheelbarrow with a heavy load (about 100 pounds) on a level surface.

    If YES, how long does this period last during the average work shift? ____hours and ____minutes

    c. Heavy…….[ ]YES [ ]NO Examples of heavy work are lifting a heavy load (about 50 pounds) 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 miles per hour; climbing stairs with a heavy load (about 50 pounds).

    If YES, how long does this period last during the average work shift? ____hours and ____minutes

19. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator?…..[ ]YES [ ]NO

    IF YES, describe this protective clothing and/or equipment: _____
    _____

20. Will you be working under hot conditions (temperature exceeding 77 degrees F.) ?…..[ ]YES [ ]NO

21. Will you be working under humid conditions?…..[ ]YES [ ]NO

22. Describe the work you will be doing while you are using your respirator(s): _____
    _____

23. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases): _____
    _____

24. Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security): _____
    _____
    _____

ECHN CorpCare
Occupational Health

2800 Tamarack Ave Suite 001
South Windsor, CT 06074
Phone 860-647-4796 Fax 860-644-0287

Evaluation for Respirator Use

Date ___/ ___/ ___/

Name:_____

Social Security Number: _____ - ____ - _____

[ ] Measured
[ ] Estimated

Measured [ ]
Estimated [ ]

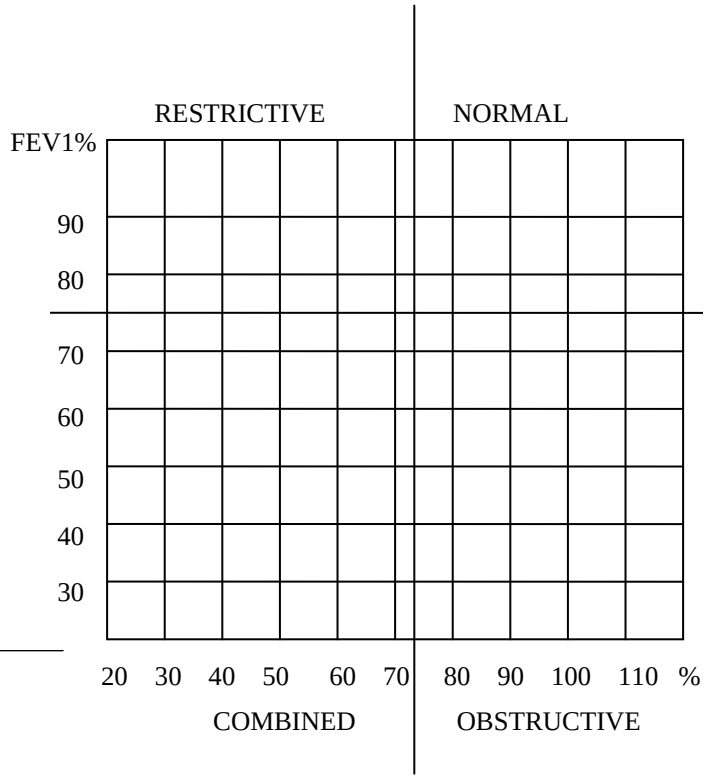
_____	_____	_____	_____	_____
M/F	Age	Ht	Wt	Race

Blood Pressure _____/_____ Smoking: _____ pack-years

FVC _____ Liters _____ percent of predicted

FEV1 _____ Liters _____ percent of predicted

FEV1/FVC _____ percent



Longitudinal monitoring (optional):

Date	FVC (Liters)	FEV1 (Liters)	FEV1/FVC
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Enter volumes, **NOT** percents of predicted.
(The percent of predicted depends on height. If different heights have been entered from year to year, then the percents of predicted will vary simply due to different height estimations. The lung volumes, however, should be accurately measured, regardless of height estimate.)

CorpCare comments: _____

_____

_____

_____
Signed

This questionnaire is required by OSHA standard 29 CFR 1910.134, Appendix C