



## NON ASBESTOS RESPIRATOR QUESTIONNAIRE FITNESS & HISTORY

**EMPLOYER:** Answers to questions in Section 1, and to Question 9 in Section 2 of Part A do not require a medical examination.

**EMPLOYEE:** Can you read?  NO  YES

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 health care professional who will review it.

### Part A – Section 1 (Mandatory)

**THE FOLLOWING INFORMATION MUST BE PROVIDED BY EVERY EMPLOYEE WHO HAS BEEN SELECTED TO USE ANY TYPE OF RESPIRATOR.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

A phone number where you can be reached by the health care professional who reviews this Questionnaire (include the Area Code):

Phone: \_\_\_\_\_ Best time to be reached: \_\_\_\_\_

Job Title & Department: \_\_\_\_\_ Company: \_\_\_\_\_

1. **Has your employer ever told you how to contact the health care professional who reviews this Questionnaire?**  
 No  Yes (if no, you can contact MOH at 651-842-5300)
2. **Check the type of respirator you will use (you can check more than one category):**  
 Disposable Respirator: non- oil resistant, resistant to oil, oil proof (Dust/filter mask, non-cartridge type only), Hepa Filter  
 Other type (i.e. Half-or full face piece type, powered air purifying, supply air, self contained Breathing apparatus).
3. **Have you ever worn a respirator?**  No  Yes if yes, what type(s)? \_\_\_\_\_

QUESTIONS 1 THROUGH 9 BELOW MUST BE ANSWERED BY EVERY EMPLOYEE WHO HAS BEEN SELECTED TO USE  
ANY TYPE OF RESPIRATOR

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 reaction that interferes with your breathing .....  Yes  No
  - d) Claustrophobia (fear of closed in places) .....  Yes  No
  - e) Trouble smelling odors .....  Yes  No
  - f) Any other symptoms that you think may be related to heart or circulation problems .....  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) Lung Cancer.....  Yes  No
  - g) Silicosis .....  Yes  No
  - h) Pneumothorax (collapsed lung).....  Yes  No
  - i) Tuberculosis.....  Yes  No
  - j) Coughing up blood in the last month.....  Yes  No
  - k) Any chest injuries or surgeries.....  Yes  No
  - l) Any other kind of lung problem that you have been told about.....  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
- c) Angina.....  Yes  No
- c) Heart Failure.....  Yes  No
- d) Swelling in your legs or feet (not caused by walking).....  Yes  No
- e) Heart arrhythmia (heart beating irregularly).....  Yes  No
- f) High blood pressure.....  Yes  No
- g) Any other heart problems that you have 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 2 years, 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 your heart or circulation..  Yes  No

**7. Do you currently take medication for the following problems?**

- a) Breathing or lung problems.....  Yes  No
- b) Heart trouble.....  Yes  No
- c) Seizures (fits). ....  Yes  No

**8. If you have used a respirator, have you ever had any of the following problems?**

- I have never used a respirator (proceed to question 9)
- a) Eye irritation.....  Yes  No
  - b) Skin allergies or rashes.....  Yes  No
  - c) Anxiety.....  Yes  No
  - d) General weakness or fatigue.....  Yes  No
  - e) Any other problems that interfere with your use of a respirator .....  Yes  No

**9. Would you like to talk to a health care professional, who will be reviewing this questionnaire, about your answers to the questions? .....**

Yes  No

**Part A – Section 2  
(Questions 10-15)**

**QUESTIONS 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.

**10. Have you ever lost vision in either eye (temporarily or permanently)? .....**

Yes  No

**11. 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

12. Have you ever had an injury to your ears, including a broken eardrum.....  Yes  No
13. Do you currently have any of the following hearing problems?  Yes  No
- a) Difficulty hearing.....  Yes  No
- b) Wearing a hearing aid.....  Yes  No
- c) Any other hearing or ear problems.....  Yes  No
14. Have you ever had a back injury?.....  Yes  No
15. Do you currently have any of the following musculoskeletal problems?  Yes  No
- a) Weakness in any of your arms, hands, legs, or feet.....  Yes  No
- b) Back pain.....  Yes  No
- c) Difficulty fully moving your arms or legs.....  Yes  No
- d) Pain or stiffness, when you lean forward at the waist.....  Yes  No
- e) Difficulty fully moving your head up or down.....  Yes  No
- f) Difficulty moving your head from side to side.....  Yes  No
- g) Difficulty bending at the knees.....  Yes  No
- h) Difficulty squatting to the ground .....  Yes  No
- i) Difficulty climbing a flight of stairs or a ladder carrying more than 25lbs.....  Yes  No
- j) Any other muscle or skeletal problems that interfere with using a respirator....  Yes  No

**Part B**

ANY OF THE FOLLOWING QUESTIONS, AND OTHER QUESTIONS NOT LISTED, MAY BE ADDED TO THE QUESTIONNAIRE AT THE DISCRETION OF THE HEALTH CARE PROFESSIONAL, WHO WILL REVIEW THE QUESTIONNAIRE.

1. In your present job, are you working at high altitudes (over 5, 000 feet), or in a place that has lower than normal amounts of oxygen?.....  Yes  No
- If yes, do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these conditions?.....  Yes  No
2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (i.e. gasses, fumes, or dust), or have you come into skin contact with hazardous chemicals?.....  Yes  No
- If yes, name the chemicals if you know them: \_\_\_\_\_
3. Have you ever worked with any of the materials or under any of the conditions listed below?
- a) Asbestosis.....  Yes  No
- b) Silica (i.e. in sandblasting).....  Yes  No
- c) Tungsten/cobalt (i.e. grinding or welding this material).....  Yes  No
- d) Beryllium.....  Yes  No
- e) Aluminum.....  Yes  No
- f) Coal (i.e. mining).....  Yes  No
- g) Iron.....  Yes  No
- h) Tin.....  Yes  No
- i) Dusty environments.....  Yes  No
- j) Any other hazardous exposures.....  Yes  No
- If yes describe these exposures: \_\_\_\_\_

- 4. List any second jobs or side businesses you have: \_\_\_\_\_
- 5. List your previous occupations: \_\_\_\_\_
- 6. List your current and previous hobbies: \_\_\_\_\_
- 7. Have you ever been in the military services? .....  Yes  No
- 8. Have you ever worked on a HazMat team?.....  Yes  No
- 9. Other than medications for breathing, lung problems, heart trouble, blood pressure, and seizures mentioned earlier, are you taking any other medications for any reason (Including over-the-counter)?.....  Yes  No

**Please sign and date below stating the fact that the information entered on this form is true to the best of your knowledge.**

**Please sign here:** \_\_\_\_\_ **date:** \_\_\_\_\_