



JOHNS HOPKINS
M E D I C I N E

Occupational Health Services
98 N. Broadway; Suite 421
Baltimore, MD 21231
410-955-6211 / FAX 410-955-1617

Respiratory Protection Questionnaire

The following questionnaire is part of the respiratory protection program requirements. Your employer must allow you time 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. Once completed please e-mail it, fax it, or send through inter-office mail to:

Occupational Health Services
98 N Broadway, Suite 421
FAX: 410 955-1617 ebibb@jhmi.edu

A staff member of Occupational Health Services will review the questionnaire. If you have questions, please feel free to call us at 410 955-6211.

Last 4 Digits of Social Security Number: _____

Date: _____ E-mail address: _____

Name: _____ Gender: Male Female

Height: _____ Weight: _____ Age: _____ Badge #: _____

Job Title: _____ Work Phone: _____

Interoffice Address: _____ Date of Birth: _____

Check the type of respirator you will use (you can check more than one category or leave blank):

- _____ N, R, or P disposable respiratory (filter-make, non cartridge type only).
- _____ Other type (i.e. half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator in the past (circle one): Yes No

If yes, what type(s): _____

MEDICAL REVIEW:

1. Do you smoke tobacco or have you smoked tobacco in the past? Yes No

Explain: _____

2. Have you ever had any of the following conditions?

Seizures Yes No

Diabetes (sugar) Yes No

Allergic reactions that interfere with your breathing Yes No

Claustrophobia (fear of closed-in places) Yes No

Trouble smelling odors Yes No

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis Yes No Asthma Yes No

Chronic Bronchitis Yes No Emphysema Yes No

Pneumonia Yes No Tuberculosis Yes No

Silicosis Yes No Pneumothorax Yes No

Lung Cancer Yes No Broken Ribs Yes No

Any chest injuries or surgeries: _____

Lung problem that you've been told about: _____

4. Do you currently have any of the following symptoms of pulmonary or lung illness:

Shortness of breath (SOB) Yes No

SOB when walking fast on level ground or up hill Yes No

SOB when walking on level ground at ordinary pace Yes No

Have to stop for breath when walking at own pace Yes No

SOB when washing or dressing self Yes No

SOB that interferes with your job Yes No

Coughing that produces phlegm (thick sputum) Yes No

Coughing that wakes you early in the morning Yes No

Coughing that occurs mostly when you are lying down Yes No

Coughing up blood in the last month Yes No

Wheezing Yes No

Wheezing that interferes with your job Yes No

Chest pain when you breathe in deeply Yes No

List any other symptoms that you may have that you think are related to lung problems: _____

5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack Yes No Year: _____

Stroke Yes No Year: _____

Angina: Yes No Explain: _____

Heart failure Yes No Diagnosed: _____

Heart palpitations Yes No

High blood pressure Yes No Diagnosed: _____

Irregular heart beat Yes No Year: _____

Leg or feet swelling Yes No Explain: _____

Frequent pain or chest tightness Yes No

Explain: _____

Pain or chest tightness during physical activity Yes No

Explain: _____

Heartburn or indigestion that is related to eating Yes No

Heart missing a beat or skipping Yes No

Explain: _____

Other heart problems you have experienced: _____

Do you have severe facial Acne? Yes No

Have you worn a respirator in the past? Yes No

If you have used a respirator in the past, have you had any of the following problems?

Eye irritation Yes No

Skin allergies or rashes from mask Yes No

Anxiety Yes No

General weakness or fatigue Yes No

Any other problem that interferes with your respirator use Yes No

Please explain any "YES" answers:

Please list current medication and reason for taking the medication.

Would you like to talk to the health care professional that will review this questionnaire?

Yes No

Thank you for taking the time to complete this questionnaire.

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Please do not write below this line.

REVIEWED BY: _____

DATE: _____