Occupational Health
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
98 N Broadway, Suite 421
FAX: 410 955-1617 or Email: ohsoffice@jhmi.edu

A staff member of Occupational Health 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	Pneumonthorax	☐ 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.

Please do not write below this line.

REVIEWED BY: _____

DATE: _____