[1] OSHA RESPIRATOR EVALUATION QUESTIONNAIRE

LADWP Occupational Health Services
111 N. Hope St. Rm 538, Los Angeles, CA 90012, (213) 367-2001

Date _____

Name _____ Emp_ID _____
(or)

Job Title _____ SSN: _____

Gender ☐ Male ☐ Female

Age _____

Height _____ ft _____ in

Weight _____ lbs

Please indicate the type of respirator you expect to use on the job.

Type of respirator you expect to use.	Wear-time frequency	Wear-time per shift
☐ Disposible respirator	☐ Daily	☐ Less than 1/2 hour
☐ Emergency Escape Breathing Apparatus	☐ Weekly	☐ 1/2 to 2 hours
☐ Powered Air-purifying Respirator (PAPR)	☐ Monthly	☐ More than 2 hours
☐ Supplied Air Respirator (Airline)	☐ Rarely	
☐ Cartridge-Filter Respirator (half or full-face)	☐ Emergency Only	
☐ Self-Contained Breathing Apparatus		

Please indicate the type of respirator you have worn before.

Type of respirator you have used before.	Wear-time frequency	Wear-time per shift
☐ Disposible respirator	☐ Daily	☐ Less than 1/2 hour
☐ Emergency Escape Breathing Apparatus	☐ Weekly	☐ 1/2 to 2 hours
☐ Powered Air-purifying Respirator (PAPR)	☐ Monthly	☐ More than 2 hours
☐ Supplied Air Respirator (Airline)	☐ Rarely	
☐ Cartridge-Filter Respirator (half or full-face)	☐ Emergency Only	
☐ Self-Contained Breathing Apparatus		

Yes No

☐ ☐ Has your employer told you how to contact the health care professional who will review this questionnaire?

Please provide the telephone number where you can be reached by the health care professional who will review this questionnaire.

Number ( ) _____- _____

Please indicate the best time to telephone you at this number: _____.

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Yes No
☐ ☐ 1. Do you currently smoke tobacco or have you smoked tobacco in the last month?

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

Yes	No		Yes	No	
☐	☐	Seizures (fits)	☐	☐	Claustrophobia (fear of closed-in spaces)
☐	☐	Diabetes (sugar disease)	☐	☐	Trouble smelling odors
☐	☐	Allergic reactions that interfere with your breathing			

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

Yes	No		Yes	No	
☐	☐	Asbestosis	☐	☐	Silicosis
☐	☐	Asthma	☐	☐	Pneumothorax (collapsed lung)
☐	☐	Chronic bronchitis	☐	☐	Lung cancer
☐	☐	Emphysema	☐	☐	Broken ribs
☐	☐	Pneumonia	☐	☐	Any chest injuries or surgeries
☐	☐	Tuberculosis	☐	☐	Any other lung problems that you've been told about

Describe _____

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

Yes	No		Yes	No	
☐	☐	Shortness of breath	☐	☐	Coughing that wakes you early in the morning
☐	☐	Shortness of breath when walking fast up a slight hill/incline	☐	☐	Coughing that occurs mostly when lying down
☐	☐	Shortness of breath when walking with others(ordinary pace)	☐	☐	Coughing up blood in the last month
☐	☐	Shortness of breath when walking alone on level ground	☐	☐	Wheezing
☐	☐	Shortness of breath when washing or dressing yourself	☐	☐	Wheezing that interferes with your job
☐	☐	Shortness of breath that interferes with your job	☐	☐	Chest pain when you breathe deeply
☐	☐	Coughing that produces phlegm (thick sputum)	☐	☐	Any other symptoms related to lung problems

Describe: _____

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

Yes	No		Yes	No	
☐	☐	Heart attack	☐	☐	Swellng in your legs or feet (not caused by walking)
☐	☐	Stroke	☐	☐	Heart arrhythmia (heart beating irregularly)
☐	☐	Angina	☐	☐	High blood pressure
☐	☐	Heart failure	☐	☐	Any other heart problems

Describe: _____

6. Have you ever had any of the following cardiovascular or heart symptoms?

Yes	No		Yes	No	
☐	☐	Frequent pain or tighness in your chest	☐	☐	Heart skipping/missing a beat, within last 2 years.
☐	☐	Pain or tightness in your chest during physical activity	☐	☐	Heartburn or indigestion that is not related to eating
☐	☐	Pain or tightness in your chest that interferes with your job	☐	☐	Any other symptoms you think may be heart related

Describe: _____

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

Yes	No		Yes	No	
☐	☐	Breathing or lung problems	☐	☐	Blood pressure
☐	☐	Heart trouble	☐	☐	Seizures (fits)

8. If you have used a respirator, have you ever had any of the following problems? ☐ Never used respirator before

Yes	No		Yes	No	
☐	☐	Eye irritation	☐	☐	Anxiety
☐	☐	Skin allergies or rashes	☐	☐	General weakness or fatigue
☐	☐	Any other problems that interferes with your use of a respirator Describe			

Yes No
☐ ☐ 9. Would you like to talk to the health care professional who will review this questionnaire regarding your answers.

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10. Have you ever lost vision in either eye?

Yes	No		Yes	No	
☐	☐	Temporarily	☐	☐	Permanently

11. Do you currently have any of the following vision problems?

Yes	No		Yes	No	
☐	☐	Wear contact lenses	☐	☐	Color blind
☐	☐	Wear glasses	☐	☐	Any other eye or vision problem

Describe _____

12. Have you ever had an injury to your ears, including a broken ear drum?

Yes	No	
☐	☐	If yes, please describe _____

13. Do you currently have any of the following hearing problems?

Yes	No		Yes	No	
☐	☐	Difficulty hearing	☐	☐	Any other hearing or ear problem
☐	☐	Wear a hearing aid			Describe _____

14. Have you ever had a back injury?

Yes	No	
☐	☐	If yes, please describe _____

15. Do you currently have any of the following musculoskeletal problems?

Yes	No		Yes	No	
☐	☐	Weakness in any of your arms, hands, legs, or feet.	☐	☐	Difficulty bending at your knees
☐	☐	Back pain	☐	☐	Difficulty squatting to the ground
☐	☐	Difficulty fully moving your arms and legs	☐	☐	Difficulty climbing a flight of stairs or a ladder
☐	☐	Pain or stiffness when you bend at the waist			carrying more than 25 lbs
☐	☐	Difficulty fully moving your head up or down	☐	☐	Any other muscle or skeletal problem that interferes
☐	☐	Difficulty fully moving your head side to side			with using a respirator.
					Describe _____

Signature _____ Date: _____