Longview Clinic
3331 Washington Way
Longview, WA 98632
360.578.2527 voice
360.575.1460 fax
www.hwnw.org

Chehalis Clinic
1522-A Bishop Road
Chehalis, WA 98532
360.740.0444 voice
360.740.0704 fax
www.hwnw.org

# RESPIRATOR CERTIFICATION QUESTIONNAIRE

**To The Employer:**
**You must not review employee questionnaires.**

**To the Employer's PLHCP:**

## Patient Information

Last ________________________________ First__________________________ M.I.______________

Birthdate _____/______/______ Social Security Number XXX/XX/_______

Job Classification________________________ Job #_________

## Company Information

Employer ______________________________________________________________________

Employer Phone Number ________________________________________________________________

**To the Employee:**
Your employer must allow you to answer this questionnaire during normal working hours, or at a 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 healthcare professional who will review it.

## Part A. Section I. MANDATORY

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

1. Your Age (to nearest year) ______________________________________________________
2. Your height ________________ft ________inches
3. Your weight ______________lbs
4. Your job title ____________________________________________________________________
5. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the Area Code) (____) ______-_______
6. The best time to call you at this phone number ______________

7. Has your employer told you how to contact the healthcare professional who will review this questionnaire? ____yes ____ no

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

| | | | |
|---|---|---|---|
| ❑ Half-mask | ❑ Full face | ❑ Helmet Hood | ❑ TB Mask |
| ❑ Non-Powdered cartridge or canister | ❑ Powdered air-purifying cartridge respirator (PARR) | ❑ Disposable filtering face-piece | ❑ Self-contained breathing apparatus (SCBA) |
| ❑ Demand | ❑ Pressure | ❑ Other | ❑ |

**Have you worn a respirator?**

| | |
|---|---|
| ❑ Yes | ❑ No |

## Part A. Section 2. MANDATORY

**Do you currently smoke or have you smoked tobacco in the last month?**

❑ YES NO

**Have you EVER had any of the following conditions?**

| | | |
|---|---|---|
| Seizures (fits)........................................................................................................ | ❑ Yes | ❑ No |
| Diabetes (sugar disease)........................................................................................ | ❑ Yes | ❑ No |
| Allergic reactions that interfere with your breathing................................................ | ❑ Yes | ❑ No |
| Claustrophobia (fear of enclosed spaces)................................................................ | ❑ Yes | ❑ No |
| Trouble smelling odors............................................................................................ | ❑ Yes | ❑ No |

**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 (collapsed lung)................................................................................ | ❑ Yes | ❑ No |
| Lung cancer........................................................................................................... | ❑ Yes | ❑ No |
| Broken Ribs........................................................................................................... | ❑ Yes | ❑ No |
| Any chest injuries or surgeries................................................................................ | ❑ Yes | ❑ No |
| Any other lung problem you've been told about........................................................ | ❑ Yes | ❑ No |

**Do you CURRENTLY have any of the following symptoms of pulmonary or lung illness?**

| | | |
|---|---|---|
| Shortness of breath................................................................................................ | ❑ Yes | ❑ No |
| Shortness of breath when walking fast on level ground or walking up a slight hill or incline...................................................................................................................... | ❑ Yes | ❑ No |
| Shortness of breath when walking with other people at an ordinary pace on level ground.................................................................................................................... | ❑ Yes | ❑ No |
| Do you have to stop for breath when walking at your own pace on level ground.................................................................................................................... | ❑ Yes | ❑ No |
| Shortness of breath when washing or dressing yourself............................................ | ❑ Yes | ❑ No |
| Shortness of breath that interferes with your job...................................................... | ❑ Yes | ❑ No |
| Coughing that produces phlegm (thick sputum)........................................................ | ❑ Yes | ❑ No |
| Coughing that wakes you up 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 |
| Chest pain when you breathe deeply | ❑ Yes | ❑ No |
| Any other symptoms that you think may be related to lung problems | ❑ Yes | ❑ No |

**Have you EVER had any of the following cardiovascular or heart problems?**

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

**Do you CURRENTLY take medication for any of the following problems?**

| | | |
|---|---|---|
| Breathing or lung problems | ❑ Yes | ❑ No |
| Heart trouble | ❑ Yes | ❑ No |
| Blood pressure | ❑ Yes | ❑ No |
| Seizures (fits) | ❑ Yes | ❑ No |

**If you've used a respirator, have you EVER HAD any of the following problems?**

| | | |
|---|---|---|
| Eye irritation | ❑ Yes | ❑ No |
| Skin allergies or rashes | ❑ Yes | ❑ No |
| Anxiety | ❑ Yes | ❑ No |
| General weakness/fatigue | ❑ Yes | ❑ No |
| Any other problems that interfere with your use of a respirator | ❑ Yes | ❑ No |

**Would you like to talk to the healthcare professional who will review this questionnaire about the answers to this questionnaire?**

| ☐ YES | ☐ NO |
|---|---|

______________________________________________

**Employee Signature**