Renown Occupational Health
Respiratory Questionnaire

To the employer: Answers to questions in Section 1, and to question 9 in Part A, Section 2 do not require a medical examination.

To the employee: Can you read this form: YES NO

If you have difficulty in seeing this form, need to have it read to you or translated in another language, contact Occupational Health.

The following information must be provided by every employee who has been selected to

Section 1 **Please Print**

Date:____________________ Job Title:____________________

Name:____________________ SS #:____________________

Gender: ___Male ___Female Height__________ft.__________in.

Phone number and email where you can be reached by the Occupational/Employee Health care professional who will review this questionnaire:

Home:( )____________________ **Cell:**( )____________________

Email:____________________

Has your employer told you how to contact the Occupational Health/Employee Health care professional who will review this form: YES NO

Check the type of Respirator you will use: (you may check more than one)

A. __________ N, R or P disposable respirator (non-cartridge type)

B.__________ Other type (example: Powered-air (PAPR), half or full face piece cartridge type, self-contained breathing apparatus)

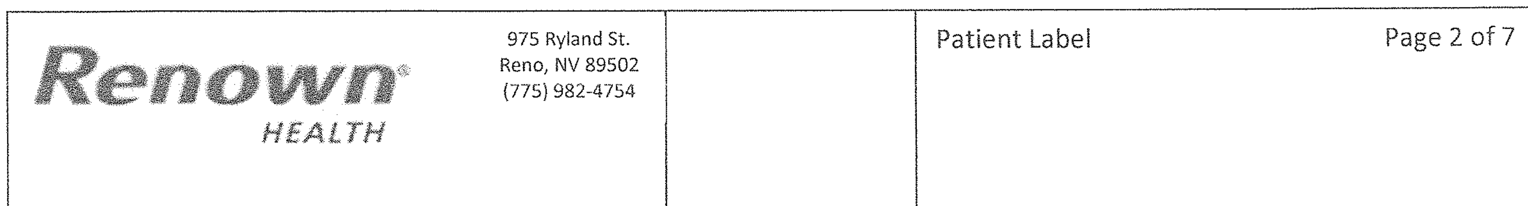
Have you ever worn a respirator? YES NO If "yes" what type(s)____________________

IF YOU HAVE FACIAL HAIR – STOP! PLEASE COMPLETE THE FACIAL HAIR WAIVER LOCATED ON THE OCCUPATIONAL HEALTH DEPARTMENT PAGE ON THE INTRANET.

Part A – Section 2 MANDATORY

QUESTIONS 1 THROUGH 9 BELOW MUST BE ANSWERED BY EVERY EMPLOYEE WHO HAS BEEN SELECTED TO USE ANY TYPE OF RESPIRATOR. PLEASE CIRCLE YES OR NO.

1. Are you currently pregnant (females only) YES NO
   If yes, STOP and call 982-4754 to schedule an appointment
2. Do you currently smoke tobacco, or have you smoked in the last month? YES NO
3. Have you ever had any of the following conditions?
   a. Seizures (fits) YES NO
   b. Diabetes (sugar disease) YES NO
   c. Allergic reactions that interfere with breathing YES NO
   d. Claustrophobia (fear of closed-in spaces) YES NO
   e. Trouble smelling odors YES NO
4. Have you ever had any of the following pulmonary or lung problems?
   a. Asbestosis YES NO
   b. Asthma YES NO
      If yes, please describe:__________
   c. Chronic Bronchitis YES NO
   d. Emphysema YES NO
   e. Pneumonia YES NO
      If yes, how many times in the last 10 years:__________
   f. Tuberculosis YES NO
   g. Silicosis YES NO
   h. Pneumothorax (collapsed lung) YES NO
   i. Lung Cancer YES NO
   j. Broken ribs YES NO
      If yes, current or multiple:__________
   k. Any chest injuries or surgeries YES NO
      If yes, please describe:__________
   l. Any other lung problems that you have told about? YES NO
      If yes, please describe:__________



5. Do you currently have any of the following symptoms of pulmonary or lung injuries?
   a. Shortness of breath YES NO
   b. Shortness of breath when walking fast on level or walking up a slight incline YES NO
   c. Have to stop for breath when walking an ordinary pace on level ground YES NO
   d. Shortness of breath when washing or dressing yourself YES NO
   e. Shortness of breath that interferes with your job YES NO
   f. Coughing that produces phlegm (thick sputum) YES NO
   g. Coughing that awakens you in the early morning YES NO
   h. Coughing that occurs mostly when you are lying down YES NO
   i. Coughing up blood in the last month YES NO
   j. Wheezing YES NO
   k. Wheezing that interfered with your job YES NO
   l. Chest pain noted with deep breath YES NO
   m. Any other lung problems, not listed above YES NO
      If yes, please describe:______________________________

      ____

6. 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
   d. Heart Failure YES NO
   e. Noted swelling in legs or feet (not caused by walking) YES NO
   f. Heart Arrhythmia's (heart beat irregularly) YES NO
   g. High blood pressure YES NO
   h. Any other heart problems no listed above YES NO
      If yes, please describe:______________________________

      ____

7. Have you ever had any of the following cardiovascular or heart symptoms listed below?
   a. Frequent pain or tightness in your chest YES NO
   b. Pain and/or tightness in your chest during physical activity YES NO
   c. Pain or tightness in your chest that may interfere with your job YES NO
   d. Have you noted your heart skipping or missing a beat with in the last 2 years YES NO
   e. Noted heartburn and/or indigestion related with eating YES NO
   f. Any other cardiac and/or circulation problems not listed above YES NO

   If yes, please describe:____

   ____

8. Do you currently take medication for any of the following?
   a. Breathing or lung problems YES NO
   b. Cardiac problems YES NO
   c. Blood pressure YES NO
   d. Seizures YES NO

9. If you previously used a respirator, did you experience any problems listed below?
   (Go to question 9 if you have never used a respirator)
   a. Eye irritation YES NO
   b. Skin rashes or allergic reaction YES NO
   c. Anxiety YES NO
   d. General weakness or fatigue YES NO
   e. Any other problems that may restrict you from use of a respirator YES NO

   If yes, please describe:____

   ____

Would you like the health care provider to go over your answers with you?
YES NO

QUESTIONS 10 TO 15 BELOW MUST BE ANSWERED BY EVERY EMPLOYEE WHO HAS BEEN SELECTED TO USE EITHER A FULL-FACE RESPIRATOR OR 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 vision problems YES NO

    If yes, please explain:____

    ____

12. Have you ever had an injury to your ears, including a broken ear drum? YES NO

13. Do you currently have any of the following hearing problems?
    a. Difficulty hearing YES NO
    b. Wear a hearing aid YES NO
    c. Any other hearing problems YES NO

    If yes, please explain:____

    ____

14. Have you ever had a back injury? YES NO

15. Do you currently have any of the following musculoskeletal problems?
    a. Weakness in any of your hands, arms, legs or feet YES NO
    b. Back Pain YES NO
    c. Difficulty fulling moving your arms and legs YES NO
    d. Pain or stiffness when you lean forward or backward at the waist YES NO
    e. Difficulty moving your head up or down YES NO
    f. Difficulty moving your head side to side YES NO
    g. Difficulty bending at your knees YES NO

h. Difficulty squatting to the ground YES NO

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs. YES NO

j. Any other muscle or skeletal problems that interferes with using a respirator YES NO

If yes, please explain:____

____

Employee acknowledgement:

Would you like a health care provider to review your answers with you?

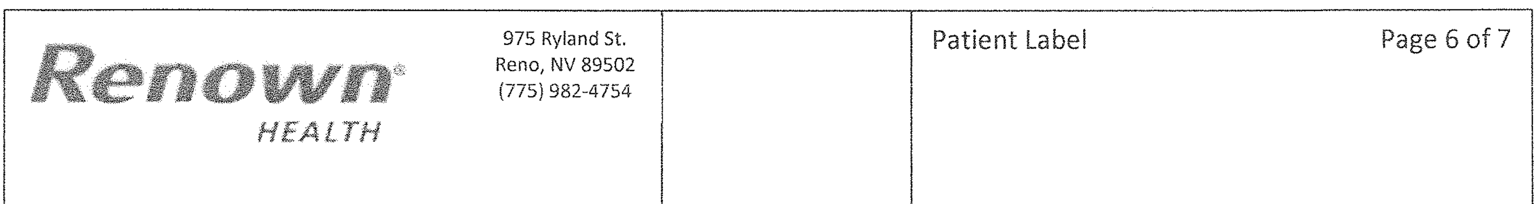
YES NO

If you would like a health care provider to review your answers with you, please be advised that this will require an appointment with Occupational Health. This appointment may or may not be available at the same time as your mask fit or spirometry appointment.

I certify that I have reviewed the foregoing respiratory history supplied by me, and to the best of my knowledge this is complete and true. I understand any false statements may lead to denial of my employment or my dismissal:

Employee Signature: ______________________ Date:______________________

EMPLOYEE: DO NOT COMPLETE ANYTHING PAST THIS POINT.



To be completed by Renown Occupational Health provider ONLY:

Healthcare provider acknowledgement:

Provider Name: ____________________________ Provider Signature: __________________________________

Date:__________________________________

975 Ryland St.
Reno, NV 89502
(775) 982-4754

Patient Label