

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):

<input type="checkbox"/> Half-mask	<input type="checkbox"/> Full face	<input type="checkbox"/> Helmet Hood	<input type="checkbox"/> TB Mask
<input type="checkbox"/> Non-Powered cartridge or canister	<input type="checkbox"/> Powered air-purifying cartridge respirator (PARR)	<input type="checkbox"/> Disposable filtering face-piece	<input type="checkbox"/> Self-contained breathing apparatus (SCBA)
<input type="checkbox"/> Demand	<input type="checkbox"/> Pressure	<input type="checkbox"/> Other	<input type="checkbox"/>

Have you worn a respirator?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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

- 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

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

- Frequent pain of tightness in your chest..... Yes No
 Pain or tightness in your chest during physical activity Yes No
 Pain or tightness in your chest that interferes with your job Yes No
 In the past two years, have you noticed your heart skipping or missing a beat Yes No
 Heartburn or indigestion that is not related to eating Yes No
 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?

<input type="checkbox"/> YES	<input type="checkbox"/> NO
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Employee Signature