PAPR / N95 Respiratory Fit

Date: _____ Name: _____

Department: _____ Phone Number:_____

Employee Number: _____

Once you have your work schedule, call the Employee Health Clinic to schedule a Respiratory Fit appointment.

Complete and send this questionnaire to the Employee Health Clinic at least 1 week prior to your appointment.

For new hires only: You have 30 days from the date of hire to complete this process.

Employee Health Clinic
800 Swift Blvd, Ste 330 (located in the Corrado Building)
Richland, WA 99352
509-942-4611, ext 4179

Required Procedures for Respiratory Protection Program

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Rule

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Rule

Part 1 - Employee Background Information
ALL employees must complete this part
Please print

1. Today's date: _____

2. Your name:_____

3. Your age (to nearest year): _____

4. Sex (circle one): Male / Female

5. Your height: _____ft. _____in.

6. Your weight: _____lbs.

7. Your job title: _____Department:_____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include Area Code): (____)_____-_____.

9. The best time to call you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire? _____ ☐ Yes ☐ No

11. Check the type of respirator(s) you will be using:

a. _____N, R, or P filtering-facepiece respirator (for example, a dust mask, OR an N95 filtering-facepiece respirator).

b. Check all that apply.

☐ Half Mask ☐ Full Facepiece Mask ☐ Helmet Hood ☐ Escape
☐ Non-powered Cartridge or Canister ☐ Powered air-purifying cartridge respirator (PAPR)

☐ Supplied-air or Air-Line

☐ Self contained breathing apparatus (SCBA) ☐ Demand or ☐ Pressure demand
Other:
_____
_

12. Have you previously worn a respirator? _____ ☐ Yes ☐ No

If "yes," describe what type(s):
_____

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Part 2 - General Health Information
ALL employees must complete this part
Please check "Yes" or "No"

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

2. 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 your breathing: ☐ Yes ☐ No

   d. Claustrophobia (fear of closed-in places): ☐ Yes ☐ No

   e. Trouble smelling odors: ☐ Yes ☐ No

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

   a. Asbestosis: ☐ Yes ☐ No

   b. Asthma: ☐ Yes ☐ No

   c. Chronic bronchitis: ☐ Yes ☐ No

   d. Emphysema: ☐ Yes ☐ No

   e. Pneumonia: ☐ Yes ☐ No

   f. Tuberculosis: ☐ Yes ☐ No

   g. Silicosis: ☐ Yes ☐ No

   h. Pneumothorax (collapsed lung): ☐ Yes ☐ No

   i. Lung cancer: ☐ Yes ☐ No

   j. Broken ribs: ☐ Yes ☐ No

   k. Any chest injuries or surgeries: ☐ Yes ☐ No

   l. Any other lung problem that you have been told about: ☐ Yes ☐ No

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

   a. Shortness of breath: ☐ Yes ☐ No

   b. Shortness of breath when walking fast on level ground or walking up a ☐ Yes ☐ No

slight hill or incline:

c. Shortness of breath when walking with other people at an ordinary pace on level ground: ☐ Yes ☐ No

d. Have to stop for breath when walking at your own pace on level ground: ☐ Yes ☐ No

e. Shortness of breath when washing or dressing yourself: ☐ Yes ☐ No

f. Shortness of breath that interferes with your job: ☐ Yes ☐ No

g. Coughing that produces phlegm (thick sputum): ☐ Yes ☐ No

h. Coughing that wakes you early in the morning: ☐ Yes ☐ No

i. Coughing that occurs mostly when you are lying down: ☐ Yes ☐ No

j. Coughing up blood in the last month: ☐ Yes ☐ No

k. Wheezing: ☐ Yes ☐ No

l. Wheezing that interferes with your job: ☐ Yes ☐ No

m. Chest pain when you breathe deeply: ☐ Yes ☐ No

n. Any other symptoms that you think may be related to lung problems: ☐ Yes ☐ No

Part 2-General Health Information (Continued)

5. 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. Swelling in your legs or feet (not caused by walking): ☐ Yes ☐ No

f. Heart arrhythmia (heart beating irregularly): ☐ Yes ☐ No

g. High blood pressure: ☐ Yes ☐ No

h. Any other heart problem that you have 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 2 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

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

a. Breathing or lung problems: ☐ Yes ☐ No

b. Heart trouble: ☐ Yes ☐ No

c. Blood pressure: ☐ Yes ☐ No

d. Seizures (fits): ☐ Yes ☐ No

8. If you have used a respirator, have you **ever had** any of the following problems? (If you have never used a respirator, check the following space and go to question 9:) ☐

a. Eye irritation: ☐ Yes ☐ No

b. Skin allergies or rashes: ☐ Yes ☐ No

c. Anxiety: ☐ Yes ☐ No

d. General weakness or fatigue: ☐ Yes ☐ No

e. Any other problem that interferes with your use of a respirator? ☐ Yes ☐ No

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

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Part 3 - Additional Questions for Users of Full-Facepiece Respirators or SCBAs Please check "Yes" or "No"	
1. Have you **ever lost** vision in either eye (temporarily or permanently)? - _____	☐ Yes ☐ No
2. Do you **currently** have any of these vision problems?	
a. Need to wear contact lenses: _____	☐ Yes ☐ No
b. Need to wear glasses: _____	☐ Yes ☐ No
c. Color blindness: _____	☐ Yes ☐ No
d. Any other eye or vision problem: _____	☐ Yes ☐ No
3. Have you **ever had** an injury to your ears, including a broken ear drum? _____	☐ Yes ☐ No
4. Do you **currently** have any of these hearing problems?	
a. Difficulty hearing: _____	☐ Yes ☐ No
b. Need to wear a hearing aid: _____	☐ Yes ☐ No
c. Any other hearing or ear problem: _____	☐ Yes ☐ No
5. Have you **ever had** a back injury? _____	☐ Yes ☐ No
6. Do you **currently** have any of the following musculoskeletal problems?	
a. Weakness in any of your arms, hands, legs, or feet: _____	☐ Yes ☐ No
b. Back pain: _____	☐ Yes ☐ No
c. Difficulty fully moving your arms and legs: _____	☐ Yes ☐ No
d. Pain or stiffness when you lean forward or backward at the waist: _____	☐ Yes ☐ No
e. Difficulty fully moving your head up or down: _____	☐ Yes ☐ No
f. Difficulty fully 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 problem that interferes with using a respirator: _____	☐ Yes ☐ No