STANFORD UNIVERSITY

OCCUPATIONAL HEALTH CENTER
480 Oak Road, Room B15
Stanford, CA 94305-8007
Phone: 650.725.5308; FAX: 650.725.9218
http://SUOHC.stanford.edu

RESPIRATOR USER BASELINE QUESTIONNAIRE

Name (Last, First MI)		Sex (M/F)	Age	Stanford ID #	Today's Date
Department / Job Title	**Supervisor / PI**	**MC**	**Work Phone**		**Best time to contact you**

INSTRUCTIONS: Your employer/supervisor must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer/supervisor must not look at or review your answers. This form will be reviewed by a health care professional at SUOHC, and maintained in your confidential medical record at the Stanford University Occupational Health Center.

1) Complete the necessary sections of this form
(Everyone completes Sections 1-2;
Full-face/SCBA/SCUBA users also complete Section 3);
2) Make a photocopy for your own records; and
3) Deliver, FAX, or mail the completed form to:

Stanford University
Occupational Health Center
480 Oak Road, Room B15
Stanford, CA 94305-8007
Phone: (650) 725-5308
FAX: (650) 725-9218

Section 1.

Have you ever used a respirator before?.. ☐ Yes ☐ No
If "yes," what type(s): ____________________

Please explain briefly: Why do you need to use a respirator now? (i.e. What exposure(s) is the respirator intended to protect you from?) ____________________

What type(s) of respirator will you need to use? (Check all that apply)
☐ Disposable Filter-Mask (N95, N99, N100) ☐ Air Purifying Half-face (cartridge-filter, ½-mask)
☐ Air Purifying Full-face(cartridge-filter) ☐ SCBA/SCUBA ☐ PAPR ☐ Other (specify)____________________

How often will you need to use a respirator?
☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

For how long each time?
☐ Minutes ☐ Hours

What other personal protective equipment will you be wearing when you use a respirator?

Will you be working in a hot or humid environment when you use a respirator? ……..…… ☐ Yes ☐ No

What will be your usual level of physical exertion when you use a respirator?
☐ Light (ex: Standing while operating a drill press)
☐ Moderate (ex: Standing while nailing or filing; lifting or carrying a load of about 25 lbs.)
☐ Heavy (ex: Shoveling; lifting or carrying a load of about 50 lbs.)

Your height: __________ ft. __________ in. Your weight: ____________ lbs.

Section 2.

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

   Have you smoked tobacco in the past? ☐ 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've 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 slight hill or incline ☐ Yes ☐ No
   - 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

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've been told about ☐ Yes ☐ No

6. **Have you <u>ever had</u> 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

7. **Do you <u>currently</u> 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've used a respirator, have you <u>ever had</u> any of the following problems?**
   (If you've **never** used a respirator, check the following box and skip to question 10.) ☐
   - 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. **Over the last year, have you had any of the following: (check all that apply)**
   - a. A change in the type of respirator you use …… ☐ Yes ☐ No
   - b. Facial scarring …… ☐ Yes ☐ No
   - c. Dental changes…… ☐ Yes ☐ No
   - d. Cosmetic surgery…… ☐ Yes ☐ No
   - e. Greater than 15% change in body weight…… ☐ Yes ☐ No

10. **Have you ever worked with any of the materials listed below:**
   - a. Asbestos…… ☐ Yes ☐ No
   - b. Silica (ex: sandblasting)…… ☐ Yes ☐ No
   - c. Tungsten/cobalt (ex: welding or grinding this material)…… ☐ Yes ☐ No
   - d. Beryllium…… ☐ Yes ☐ No
   - e. Lead…… ☐ Yes ☐ No
   - f. Aluminum…… ☐ Yes ☐ No
   - g. Other hazardous exposures (Describe:______________________________).. ☐ Yes ☐ No

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

Today's Date: __________________ Signature: ____

Clinician Notes: ____

____

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Reviewing Clinician Signature:______________________________ Date: __________________

Section 3.

IF YOU NEED TO USE EITHER A FULL-FACEPIECE RESPIRATOR OR A SELF-CONTAINED BREATHING APPARATUS (SCBA/SCUBA), COMPLETE QUESTIONS 11 TO 16 BELOW.

11. Have you ever lost vision in either eye (temporarily or permanently)? …………………………….. ☐ Yes ☐ No

12. 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 eye or vision problem ………………………………………………………….... ☐ Yes ☐ No

13. Have you ever had an injury to your ears, including a broken ear drum? ………………………….☐ Yes ☐ No

14. 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 or ear problem ………………………………………………………………… ☐ Yes ☐ No

15. Have you ever had a back injury? ……………………………………………………………….. ☐ Yes ☐ No

16. 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

Today's Date: ___________________ **Signature:** ____

Clinician Notes: ____
____
____

Reviewing Clinician Signature:_________________________________ **Date:** _________________