

**Duke University Employee Occupational Health and Wellness  
QUESTIONNAIRE FOR RESPIRATOR USERS**

*Employees who need respiratory protection against M. Tuberculosis, SARS,  
or other particulates found in clinical settings*

The Occupational Safety and Health Administration (OSHA) requires that the following information be provided by every employee who has been selected to use any type of respirator (please print). If you have any questions regarding the first two pages, you may talk to your supervisor or call the Occupational and Environmental Safety Office (OESO) at 684-5996.

Can you read?       Yes       No

Your employer 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 supervisor must not look at or review your answers to the medical portion of this questionnaire. **When completed, this form should be sent in a sealed envelope to Employee Occupational Health and Wellness, Box 3148 Medical Center.**

Your name: \_\_\_\_\_ Your Work Phone: \_\_\_\_\_  
Your Duke ID (If known): \_\_\_\_\_ Daytime phone, if different: \_\_\_\_\_  
Your Department: \_\_\_\_\_ Box# \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Your Job Title: \_\_\_\_\_ Sex:     Male       Female  
Supervisor's Name: \_\_\_\_\_ Today's date: \_\_\_\_\_

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

PAPR or N-95

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> N, R, or P disposable respirator (filter-mask, non-cartridge type only). (<11lb) | <input type="checkbox"/> supplied air, hood (<3 lbs)                                   |
| <input type="checkbox"/> air-purifying, half mask (< 1 lb)   | <input type="checkbox"/> supplied air, tight fitting (2 –4 lbs)                        |
| <input type="checkbox"/> air-purifying, full mask (1-3 lbs)  | <input type="checkbox"/> Self-Contained Breathing Apparatus (SCBA) (24 lbs)            |
| <input checked="" type="checkbox"/> powered air-purifying hood (<4 – 12 lbs)   | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> powered air-purifying, tight fitting (< 5 lbs)  | Use is <input checked="" type="checkbox"/> Required <input type="checkbox"/> Voluntary |

**Please indicate your level of work effort while using the respirator, indicating the amount of time you would spend at each level in a day:**

- | Level of Effort                                | Examples   |
|--|--|
| <input type="checkbox"/> light      ___ hours  | typing, operating a drill press.                                 |
| <input type="checkbox"/> moderate    ___ hours | Nailing, assembly work, pushing a wheelbarrow on a level surface |
| <input type="checkbox"/> heavy      ___ hours  | Heavy lifting, shoveling, climbing stairs with a heavy load      |

**How often are you expected to use the respirator?**

- |   |   |
|---|---|
| <input type="checkbox"/> Escape only                | <input type="checkbox"/> Daily, for less than 2 hours per day |
| <input type="checkbox"/> Emergency only             | <input type="checkbox"/> Daily, for 2 - 4 hours per day       |
| <input type="checkbox"/> Less than 5 hours per week | <input type="checkbox"/> Daily, more than 4 hours per day     |

**For Employee Occupational Health Services (EOHS) use only:**

Medically approved for     All air-purifying respirators     Supplied Air Respirators     SCBA  
 Other: \_\_\_\_\_

Restrictions:  Employee may decline respirator-requiring assignments for temporary health-related difficulties  
 Other: \_\_\_\_\_

Effective through \_\_\_\_\_ OR  Complete brief questionnaire at time of annual training (Required users only)

Employee has been provided with a copy of this written recommendation:     Yes       No

Signature of Physician or Other Licensed Health Care Professional: \_\_\_\_\_  
(Criteria: EE has health problems – Use medical judgment; No relevant health problems: indefinite clearance (20 years).)

Employee SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Employee Name \_\_\_\_\_

**Your Age** (to nearest year): \_\_\_\_ **Your Weight:** \_\_\_\_ lbs. **Your Height:** \_\_\_\_ ft. \_\_\_\_ in.

Have you worn a respirator?  Yes  No

If yes, what type(s)? \_\_\_\_\_

**On the list below, please check any types of personal protective equipment you may be wearing when using your respirator. ( None)**

- Gloves  Hearing protection  Apron or lab coat  
 Eye protection  Hard hat  Full body suit PPE  
 Other (Please describe) \_\_\_\_\_

**Will you be working under hot conditions?** (above 85 deg. F):  Yes  No

**Will you be working under humid conditions?**  Yes  No

**Describe the work you'll be doing while using your respirator(s):**

\_\_\_\_\_

**Describe any special or hazardous conditions you might encounter when using your respirator(s) (for example, confined spaces, life-threatening gases):**

\_\_\_\_\_

**Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue or security):**

\_\_\_\_\_

**Provide the following information, if you know it, for each potentially hazardous substance that you'll be exposed to when using your respirator(s).**

Name of potentially hazardous substance	Estimated Maximum Exposure Level	Duration of exposure (# hours/week)
Airborne M. tuberculosis	?	
Airborne SARS pathogen	?	
Other airborne particulates	?	

Signature of Safety Personnel Courtney V Stanion Date 2-6-04

Has your employer told you how to contact the health care professional who will review this questionnaire? (Call Employee Health at 684-3136.)  Yes  No

Employee SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employee Name \_\_\_\_\_

**Questions 1 through 9\*\* below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no").** Employee Occupational Health and Wellness (EOHW) at 684-3136 can assist you with this portion of the questionnaire.

	Yes	No		Yes	No
<b>1. Do you <u>currently</u> smoke tobacco, or have you smoked tobacco in the last month?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>5. Do you <u>currently</u> have any of the following symptoms of pulmonary or lung illness?</b>		
<b>2. Have you <u>ever had</u> any of the following conditions?</b>			a. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
a. Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>	c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>	d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
d. Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>	e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>	f. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
f. Heat stroke	<input type="checkbox"/>	<input type="checkbox"/>	g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Have you <u>ever had</u> any of the following pulmonary or lung problems?</b>			h. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
a. Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>	i. Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	j. Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	k. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	l. Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
e. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	m. Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
f. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	n. Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/>
g. Silicosis	<input type="checkbox"/>	<input type="checkbox"/>	<b>6. Have you <u>ever had</u> any of the following cardiovascular or heart symptoms?</b>		
h. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>	a. Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>
i. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	b. Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>
j. Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>	c. Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
k. Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>	d. In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
l. Any other lung problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>			
<b>4. Have you <u>ever had</u> any of the following cardiovascular or heart problems?</b>					
a. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>			
b. Stroke	<input type="checkbox"/>	<input type="checkbox"/>			
c. Angina	<input type="checkbox"/>	<input type="checkbox"/>			
d. Heart failure	<input type="checkbox"/>	<input type="checkbox"/>			
e. Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>			
f. Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>			
g. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			
h. Any other heart problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>			

Employee SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employee Name \_\_\_\_\_

- 6 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

**\*\*Briefly explain "Yes" answers:**

\_\_\_\_\_  
\_\_\_\_\_

**8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check no on this line 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 to this questionnaire?**

- Yes  No

**Questions 10 to 15\*\* below must be answered by every employee who has been selected to use either a full-facepiece respirator or a 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 eye or vision problem  Yes  No

- 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 or ear problem  Yes  No

- 14. Have you ever had a back injury?  Yes  No

**\*\*Briefly explain "Yes" answers:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**15. 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 pounds  Yes  No
- j. Any other muscle or skeletal problem that interferes with using a respirator  Yes  No