

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

Police and Security Officers Only

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 919-684-5996.

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 emailed as an attachment to Employee Occupational Health at EOHW21@dm.duke.edu**

Your name: _____

Your work phone: _____

Your Duke ID (If known): _____

Daytime phone, if different: _____

Your department: Police 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):

- | | |
|--|--|
| ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only) (<1 lb) | ☐ supplied air, hood (<3 lbs) |
| ☐ air-purifying, half mask (< 1 lb) | ☐ supplied air, tight fitting (2 –4 lbs) |
| ☒ air-purifying, full mask (1-3 lbs) | ☐ Self-contained breathing apparatus (SCBA) (24 lbs) |
| ☐ powered air-purifying hood (<4 – 12 lbs) | ☐ Other: _____ |
| ☐ powered air-purifying, tight fitting (~12 lbs) | Use is ☒ Required ☐ 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 |
|--|--|
| ☐ light _____ hours | typing, operating a drill press. |
| ☒ moderate _____ hours | Nailing, assembly work, pushing a wheelbarrow on a level surface |
| ☒ heavy _____ hours | Heavy lifting, shoveling, climbing stairs with a heavy load |

How often are you expected to use the respirator?

- | | |
|---|---|
| ☐ Escape only | ☐ Daily, for less than 2 hours per day |
| ☒ Emergency only | ☐ Daily, for 2 - 4 hours per day |
| ☐ Less than 5 hours per week | ☐ 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: Most working conditions: indefinite clearance (20 years); Any working conditions with SCBA: 2 years from present date.)

Duke ID _____

Employee Name _____

Age (to nearest year): _____ **Weight:** _____ lbs. **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 will 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°F):

☒ Yes

☐ No

Will you be working under humid conditions?

☒ Yes

☐ No

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

Dealing with patients who have been exposed to hazardous chemicals, radiation, or biological hazards

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

IDLH atmospheres may be encountered

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)
Industrial chemicals	?	
Chemical, radiological or biological weapon residue (on terrorist victim)	?	

Signature of Safety Personnel

Stephanie Caler

Date: 09/03/2026

Has your employer told you how to contact the health care professional who will review this questionnaire? (Call Employee Health at 919-684-3136.)

☐ Yes ☐ No

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 at 919-684-3136 can assist you with this portion of the questionnaire.

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

Duke ID _____

Employee Name _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 6 e. Heartburn or indigestion that is not related to eating | ☐ | ☐ |
| f. Any other symptoms that you think may be related to heart or circulation problems | ☐ | ☐ |

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

- | | | |
|-------------------------------|--------------------------|--------------------------|
| a. Breathing or lung problems | ☐ | ☐ |
| b. Heart trouble | ☐ | ☐ |
| c. Blood pressure | ☐ | ☐ |
| d. Seizures | ☐ | ☐ |

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

- | | 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 no on this line and go to question 9) | | |

- | | | |
|--|--------------------------|--------------------------|
| a. Eye irritation | ☐ | ☐ |
| b. Skin allergies or rashes | ☐ | ☐ |
| c. Anxiety | ☐ | ☐ |
| d. General weakness or fatigue | ☐ | ☐ |
| 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?	☐	☐

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.**

- | | Yes | No |
|---|--------------------------|--------------------------|
| 10. Have you <u>ever lost</u> vision in either eye (temporarily or permanently)? | ☐ | ☐ |

11. Do you currently have any of the following vision problems?

- | | | |
|------------------------------------|--------------------------|--------------------------|
| a. Wear contact lenses | ☐ | ☐ |
| b. Wear glasses | ☐ | ☐ |
| c. Color blind | ☐ | ☐ |
| d. Any other eye or vision problem | ☐ | ☐ |

12. Have you ever had an injury to your ears, including a broken ear drum?

☐	☐
--------------------------	--------------------------

13. Do you currently have any of the following hearing problems?

- | | | |
|-------------------------------------|--------------------------|--------------------------|
| a. Difficulty hearing | ☐ | ☐ |
| b. Wear a hearing aid | ☐ | ☐ |
| c. Any other hearing or ear problem | ☐ | ☐ |

14. Have you ever had a back injury?

☐	☐
--------------------------	--------------------------

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

15. Do you currently have any of the following musculoskeletal problems?

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Weakness in any of your arms, hands, legs, or feet | ☐ | ☐ |
| b. Back pain | ☐ | ☐ |
| c. Difficulty fully moving your arms and legs | ☐ | ☐ |
| d. Pain or stiffness when you lean forward or backward at the waist | ☐ | ☐ |
| e. Difficulty fully moving your head up or down | ☐ | ☐ |
| f. Difficulty fully moving your head side to side | ☐ | ☐ |
| g. Difficulty bending at your knees | ☐ | ☐ |
| h. Difficulty squatting to the ground | ☐ | ☐ |
| i. Climbing a flight of stairs or a ladder carrying more than 25 pounds | ☐ | ☐ |
| j. Any other muscle or skeletal problem that interferes with using a respirator | ☐ | ☐ |