DEPARTMENT OF HOMELAND SECURITY

U.S. Coast Guard

RESPIRATOR QUESTIONNAIRE

Your 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 supervisor *(or anyone in the chain of command)* must not look at or review your answers.

PART A: Section 1.

Today's Date	Name Including Middle Initial	Job Title	
Sex *(Male or Female)*	Your Age *(to the nearest year)*	Your Height _____ ft. _____ in.	Your Weight in lbs.
Phone number where you can be reached by the Medical Officer/ Healthcare Provider reviewing this questionnaire *(include Area Code):*			Best time to call:
E-mail Address of your CO	E-mail Address of your XO/XPO		

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

- ☐ N, R, or P disposable respirator *(filter-mask, non-cartridge type only)*
- ☐ Cartridge-type respirator *(filter-mask with any type of cartridges)*
- ☐ Powered Air Purifying Respirator
- ☐ Supplied Air Respirator
- ☐ Self Contained Breathing Apparatus *(SCBA)*
- ☐ Other type of respirator Describe: _____

Have you ever/previously worn a respirator? ☐ **Yes** ☐ **No**

If YES, what type(s):

PART A. Section 2. Please respond to the following questions by checking YES or NO or providing the requested information.
IF POSSIBLE PROVIDE ADDITIONAL INFORMATION BESIDE YOUR ANSWERS.

	YES	NO
1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you ever had any of the following conditions?	YES	NO
a. Seizures *(fits)*	☐	☐
b. Diabetes *(sugar disease)*	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia *(fear of closed spaces)*	☐	☐
e. Trouble smelling odors	☐	☐
3. Have you **ever had** any of the following pulmonary or lung problems?	YES	NO
a. Asbestosis	☐	☐
b. Asthma	☐	☐
c. Chronic bronchitis	☐	☐
d. Emphysema	☐	☐
e. Pneumonia	☐	☐
f. Tuberculosis	☐	☐
g. Silicosis	☐	☐
h. Pneumothorax *(collapsed lung)*	☐	☐

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Full Name	Today's Date	
	YES	NO
j. Lung cancer	☐	☐
k. Broken ribs	☐	☐
l. Any chest injuries or surgeries	☐	☐
m. Any other lung problem that you've been told about. Describe below:	☐	☐
4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?	YES	NO
a. Shortness of breath	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
d. Have to stop for breath when walking at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐
f. Shortness of breath that interferes with the job	☐	☐
g. Coughing that produces phlegm *(thick sputum)*	☐	☐
h. Coughing that wakes you early in the morning	☐	☐
i. Coughing that occurs mostly when you are lying down	☐	☐
j. Coughing up blood in the last month	☐	☐
k. Wheezing	☐	☐
l. Wheezing that interferes with the job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. Any other symptoms that you think may be related to lung problems. Describe below:	☐	☐
5. Have you **ever had** any of the following cardiovascular or heart problems?	YES	NO
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 have been told about. Describe below:	☐	☐
6. Have you **ever had** any of the following cardiovascular or heart symptoms?	YES	NO
a. Frequent pain or tightness in your chest	☐	☐
b. Pain or tightness in your chest during physical activity	☐	☐
c. Pain or tightness in your chest that interferes with your job	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
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. Describe below:	☐	☐

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7. Do you **currently use** medications for any of the following problems?	YES	NO
a. Breathing or lung problems	☐	☐
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures *(fits)*	☐	☐
8. If you've ever used a respirator, check the "YES" box to the right, and continue with questions 8a through 8e. *(If you've never used a respirator, check the "NO" box to the right and continue with question 9.)*	☐	☐
a. Eye irritation	☐	☐
b. Skin allergies or rashes	☐	☐
c. Anxiety	☐	☐
d. General weakness or fatigue	☐	☐
e. Any other symptoms that interfere with your use of a respirator	☐	☐
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	☐	☐
10. Have you **ever lost** vision in either eye *(temporary or permanently)*?	☐	☐
11. Do you **currently** have any of the following vision problems?	YES	NO
a. Wear contact lenses	☐	☐
b. Wear glasses	☐	☐
c. Color blind	☐	☐
d. Any other eye or vision problems. Describe below:	☐	☐
12. Have you **ever had** an injury to your ears, including a broken ear drum?	☐	☐
13. Do you **currently** have any of following hearing problems?	YES	NO
a. Difficulty hearing	☐	☐
b. Wearing a hearing aid	☐	☐
c. Any other hearing or ear problem. Describe below:	☐	☐
14. Have you **ever had** a back injury?	☐	☐
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 moving your head up or down	☐	☐
f. Difficulty moving your head side to side	☐	☐
g. Difficulty bending at your knees	☐	☐
h. Difficulty squatting to the ground	☐	☐
i. Difficulty 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	☐	☐

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Full Name	Today's Date

Part B.	YES	NO
1. List any medications you are taking here:		
2. How often are you expected to use the respirator(s)? Select "YES" or "NO" for all answers that apply to you.	YES	NO
a. Escape only *(no rescue)*	☐	☐
b. Emergency rescue only	☐	☐
c. Less than 5 hours **per week**	☐	☐
d. Less than 2 hours **per day**	☐	☐
e. 2-4 hours per day	☐	☐
f. Over 4 hours per day	☐	☐
3. During the period you are using the respirator(s), is your work effort:	YES	NO
a. **Light** *(less than 200 kcal per hour) Examples are performing light assembly work; or standing while controlling machines.*	☐	☐
If "YES," how long does this period last during an average shift: _____ hrs. _____ mins.		
b. **Moderate** *(200-350 kcal per hour) Examples are standing while drilling or nailing; transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph; or pushing a wheelbarrow with a heavy load (100 lbs) on a level surface.*	☐	☐
If "YES," how long does this period last during an average shift: _____ hrs. _____ mins.		
c. **Heavy** *(above 350 kcal per hour) Examples are lifting a heavy load (50 lbs) from floor to your waist or shoulder; shoveling; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load.*	☐	☐
If "YES," how long does this period last during an average shift: _____ hrs. _____ mins.		
4. Will you be wearing protective clothing and/or equipment *(other than the respirator)* when you're using your respirator?	☐	☐
If "YES," describe this protective clothing and/or equipment below:		
5. Will you be working under hot conditions *(exceeding 77 degrees F)*?	☐	☐
6. Will you be working under humid conditions?	☐	☐

7. Provide the name of each toxic substance that you'll be exposed to when you are using your respirator and number of hours exposed per shift to each substance.

Initial review by licensed healthcare provider (nurse/NP/PA/physician). For a positive response in Part A, Section 2 to question 9, the healthcare provider must answer employee's questions. For positive responses in Part A, Section 2 to questions 1-8 for non-SCBA users and to questions 1-8 or 10-15 for SCBA users, a medical appointment should be scheduled with a Medical Officer/ Healthcare Provider.

Privacy Act Statement

The collection and use of this information is authorized by 5 U.S.C. 7901, 5 U.S.C. 339, 5 U.S.C. 301, 10 U.S.C. §1074, 14 U.S.C. § 93 (a) (17), 29 C.F.R. § 1630.14, and Executive order 12196. The information will become part of the official Employee Medical File, and will be used to assist the Coast Guard in carrying out its occupational health services responsibilities and for other official purposes and routine uses as described in Privacy Act systems notice OPM/ GOVT-10. Providing the requested information is voluntary for civilian employees. Not providing the information may affect the availability and quality of the health services rendered to the employee and may also affect the completeness of information used in making determinations of medically-related employment decisions.

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