City of Seattle Respiratory Protection Questionnaire

To the Licensed Health Care Provider Reviewing:

1. The Employee Respiratory Protection Information (ERPI) form **MUST** be attached to this questionnaire for proper evaluation. Is ERPI Attached? Yes: ☐ No: ☐
2. Does the Employee agree with the information supplied on the ERPI form?
   If yes, check here ☐
   If no (please make comments on the ERPI form and return a copy to City with the comments) ☐

To the Employee Completing this form: Your confidentiality is protected in accordance with public law. Neither supervisors nor any other City employee are provided with your individual information. Please complete the following. ***Note: Form must be signed and dated to be valid***.

_____ _____
Name (please print) Job Title

_____ _____
Address (Street) Address (City, State, Zip Code)

_____ _____ _____
Employee ID# if known Department Low Org #

_____ _____
Signature Date

Part 1 – Employee Background Information – ALL employees must complete this section
(Please Print)

Male ❑ Female ❑

_____	_____	_____	_____	_____
Date of Birth	Age	Sex	Height (Ft. & Inch)	Weight (Lbs.)

1. _____ 2. _____ 3. _____ 4. _____

Phone number(s) where you can be reached by the health care provider who reviews this form.

_____ _____ _____ _____
Best time to contact you at the number(s) listed

Has your employer told you how to contact the health care provider who reviews this questionnaire?
Yes ❑ No ❑ Call The Work Clinic – Tukwila @ (206) 243-9675 **or** The Work Clinic – Seattle @ (206) 995-8868

You may be contacted by The Work Clinic if there are questions about your responses to this questionnaire.

Without complete information **RESPIRATORY MEDICAL CLEARANCE** may be delayed or may not be issued.

Name _____

Part 2 – General Health Information

ALL employees must complete this part – Please check "Yes" or "No"

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 condition?

Yes ☐ No ☐ 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

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

Yes ☐ No ☐ a. Asbestosis
Yes ☐ No ☐ b. Asthma
-***If you checked yes, if not continue to c***
I. Are you under a doctor's care? Yes ☐ No ☐
II. Do you take medications for this problem? Yes ☐ No ☐
III. Have you had worsening of the problem in the last year requiring an urgent appointment, hospital admission or emergency room evaluation? Yes ☐ No ☐
Yes ☐ No ☐ c. Chronic bronchitis
-***If you checked yes, if not continue to d***
I. Are you under a doctor's care? Yes ☐ No ☐
II. Do you take medications for this problem? Yes ☐ No ☐
III. Have you had worsening of the problem in the last year requiring an urgent appointment, hospital admission or emergency room evaluation? Yes ☐ No ☐
Yes ☐ No ☐ d. Emphysema
-***If you checked yes, if not continue to e***
I. Are you under a doctor's care? Yes ☐ No ☐
II. Do you take medications for this problem? Yes ☐ No ☐
III. Have you had worsening of the problem in the last year requiring an urgent appointment, hospital admission, or emergency room evaluation? Yes ☐ No ☐
Yes ☐ No ☐ e. Pneumonia (if no continue to f)
-***If you checked yes,*** have you completed treatment? Yes ☐ No ☐
Yes ☐ No ☐ f. Tuberculosis
Yes ☐ No ☐ g. Silicosis
Yes ☐ No ☐ h. Pneumothorax (collapsed lung)
Yes ☐ No ☐ i. Lung Cancer
Yes ☐ No ☐ j. Broken ribs (if no continue to k)
-***If you checked yes,*** do you have any residual pain or symptoms? Yes ☐ No ☐
Yes ☐ No ☐ k. Any chest injuries or surgeries (if no continue to l)
-***If you checked yes,*** have you completed treatment? Yes ☐ No ☐
Yes ☐ No ☐ l. Any other lung problem that you have been told about?

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

Yes ☐ No ☐ a. Shortness of breath
Yes ☐ No ☐ b. Shortness of breath walking fast on level ground or walking up a slight hill or incline
Yes ☐ No ☐ c. Shortness of breath 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 bathing 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?

5. Have you ever had any of the following cardiovascular or heart problems?

Yes ☐ No ☐ 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

-***If you checked yes, if not continue to h***

I. Are you under a doctor's care? Yes ☐ No ☐
II. Do you take medications for this problem? Yes ☐ No ☐
III. Have you had worsening of the problem in the last year requiring an urgent appointment, hospital admission, or emergency room evaluation? Yes ☐ No ☐
IV. Is your blood pressure under 140/90? Yes ☐ No ☐

Yes ☐ No ☐ h. Any other heart problem that you have been told about?

6. Have you ever had any of the following cardiovascular or heart symptoms?

Yes ☐ No ☐ 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?

-***If you checked yes, if not continue to e***

I. Are you under a doctor's care? Yes ☐ No ☐
II. Do you take medications for this problem? Yes ☐ No ☐
III. Have you had worsening of the problem in the last year requiring an urgent appointment, hospital admission, or emergency room evaluation? Yes ☐ No ☐
IV. Has this been diagnosed as PVCs or PACs? Yes ☐ No ☐

Yes ☐ No ☐ e. Heartburn or indigestion that isn't related to eating
Yes ☐ No ☐ 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?

Yes ☐ No ☐ a. Breathing or lung problems
Yes ☐ No ☐ b. Heart trouble
Yes ☐ No ☐ c. Blood pressure
Yes ☐ No ☐ d. Seizures (fits)

8. If you have used a respirator, have you **ever had** any of the following problems?
(If you have never used a respirator, write N/A in the column to the left and go to question 9.)

Yes ☐ No ☐ a. Eye irritation -***If you checked yes, if not continue to b***

I. Was this a limited event that resolved within a day? Yes ☐ No ☐
II. Did it interfere with your ability to continue to use the respiratory equipment at the time? Yes ☐ No ☐

Yes ☐ No ☐ b. Skin allergies or rashes -***If you checked yes, if not continue to c***

I. Was this a limited event that resolved within a day? Yes ☐ No ☐
II. Did it interfere with your ability to continue to use the respiratory equipment at the time? Yes ☐ No ☐

Yes ☐ No ☐ c. Anxiety

Name _____

Yes ☐ No ☐ d. General weakness or fatigue
Yes ☐ No ☐ e. Any other problem that interferes with your use of a respirator?

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

Part 3 – Additional Questions for Users of Full-Facepiece Respirators or SCBAs
Please check "Yes" or "No"

Yes ☐ No ☐ 1. Have you **ever lost** vision in either eye (temporarily or permanently)?

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2. Do you **currently** have any of these vision problems?
Yes ☐ No ☐ 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?
-***If you checked yes, if not continue to 4***
I. Is the injury healed? Yes ☐ No ☐
II. Do you have ongoing drainage from the ear? Yes ☐ No ☐
III. Does it still hurt? Yes ☐ No ☐

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4. Do you **currently** have any of these hearing problems?
Yes ☐ No ☐ 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?

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6. Do you **currently** have any of the following musculoskeletal problems?
Yes ☐ No ☐ a. Back pain
Yes ☐ No ☐ b. Difficulty fully moving your arms and legs
Yes ☐ No ☐ c. Pain or stiffness when you lean forward or backward at the waist
Yes ☐ No ☐ d. Difficulty fully moving your head up or down
Yes ☐ No ☐ e. Difficulty fully moving your head side to side
Yes ☐ No ☐ f. Difficulty bending at your knees
Yes ☐ No ☐ g. Difficulty squatting to the ground
Yes ☐ No ☐ h. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.
Yes ☐ No ☐ i. Any other muscle or skeletal problem not previously mentioned?
Yes ☐ No ☐ **If you responded yes to ANY of the above,** do these symptoms impair your ability to put on, carry, use, or remove the SCBA and other respiratory protection equipment?

Yes ☐ No ☐ 7. Do you now have, or have you ever had, weakness in any of your arms, hands, legs, or feet?

Part 4 – Please list all medications that you are currently taking:

Name of Medication	Dose (e.g. 250mg)	Frequency (e.g. once daily)