INDUSTRIAL SAFETY SERVICES, INC.
PO Box 571
Springfield, Oregon 97477
541-746-7622

Confidential

Note: This information will only be reviewed by a health care provider to evaluate whether or not you are medically qualified to wear a respirator.

(Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

COMPANY					
LAST		**FIRST**		**MI**	
AGE	yrs **DOB** M/D/Y	**SEX**	**M F** Circle one		
HEIGHT	FT/IN	**WEIGHT**	LBS		
JOB TITLE					
PHONE		**Best Time To Call**			

Dr. Patrick Merrick or Dr. Barry Jarvis will review this questionnaire for approval purposes.

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

A. _______ Filtering Face-Piece **(non- cartridge type only).**

B. _______ Non-Disposable Cartridge or Supplied Air Type**.**

If Non-Disposable respirator is used describe below:

Brand: _______________ Model: ______________ Type: ___________________

Reason for use of respirator:

Have you ever worn a respirator (circle one): Yes - No

If "yes," what types?

Please circle "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 conditions?		
YES	NO	Seizures (fits):
YES	NO	Diabetes (sugar disease):
YES	NO	Allergic reaction that interfere with your breathing
YES	NO	Claustrophobia (fear of closed-in places)
YES	NO	Trouble smelling odors
3. Have you *ever had* any of the following pulmonary or lung problems?		
YES	NO	Asbestosis
YES	NO	Asthma
YES	NO	Chronic bronchitis
YES	NO	Emphysema
YES	NO	Pneumonia
YES	NO	Tuberculosis
YES	NO	Silicosis
YES	NO	Pneumothorax (collapsed lung):
YES	NO	Lung cancer
YES	NO	Broken ribs
YES	NO	Any chest injuries or surgeries:
YES	NO	Any other lung problem that you've been told about
4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?		
YES	NO	Shortness of breath
YES	NO	Shortness of breath when walking fast on level ground or walking up a slight hill or incline
YES	NO	Shortness of breath when walking with other people at an ordinary pace on level ground
YES	NO	Have to stop for breath when walking at your own pace on level ground
YES	NO	Shortness of breath when washing or dressing yourself
YES	NO	Shortness of breath that interferes with your job
YES	NO	Coughing that produces phlegm (thick sputum):
YES	NO	Coughing that wakes you early in the morning
YES	NO	Coughing that occurs mostly when you are lying down
YES	NO	Coughing up blood in the last month
YES	NO	Wheezing
YES	NO	Wheezing that interferes with your job
YES	NO	Chest pain when you breathe deeply
YES	NO	Any other symptoms that you think may be related to lung problems
		Please explain:
5. Have you *ever had* any of the following cardiovascular or heart problems?		
YES	NO	Heart attack
YES	NO	Stroke
YES	NO	Angina
YES	NO	Heart failure
YES	NO	Swelling in your legs or feet (not caused by walking)
YES	NO	Heart arrhythmia (heart beating irregularly)
YES	NO	High blood pressure
YES	NO	Any other heart problem that you've been told about

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6. Have you *ever had* any of the following cardiovascular or heart symptoms?		
YES	NO	Frequent pain or tightness in your chest
YES	NO	Pain or tightness in your chest during physical activity
YES	NO	Pain or tightness in your chest that interferes with your job:
YES	NO	In the past two years, have you noticed your heart skipping or missing a beat
YES	NO	Heartburn or indigestion that is not related to eating
YES	NO	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	Breathing or lung problems
YES	NO	Heart trouble
YES	NO	Blood pressure
YES	NO	Seizures (fits)
8. If you've used a respirator, have you *ever had* any of the following problems?		
YES	NO	Eye irritation
YES	NO	Skin allergies or rashes
YES	NO	Anxiety
YES	NO	General weakness or fatigue
YES	NO	Any other problem that interferes with your use of a respirator
YES	NO	**9. Have you ever lost vision in either eye? (temporarily or permanent)**
10. Do you *currently* have any of the following vision problems?		
YES	NO	Wear contact lenses
YES	NO	Wear glasses
YES	NO	Color blind
YES	NO	Any other eye or vision problem
YES	NO	**11. Have you *ever had* an injury to your ears, including a broken ear drum?**
12. Do you *currently* have any of the following hearing problems?		
YES	NO	Difficulty hearing
YES	NO	Wear a hearing aid
YES	NO	Any other hearing or ear problem
YES	NO	**13. Have you *ever had* a back injury?**
14. Do you *currently* have any of the following musculoskeletal problems?		
YES	NO	Weakness in any of your arms, hands, legs, or feet
YES	NO	Back pain
YES	NO	Difficulty fully moving your arms and legs
YES	NO	Pain or stiffness when you lean forward or backward at the waist
YES	NO	Difficulty fully moving your head up or down
YES	NO	Difficulty fully moving your head side to side
YES	NO	Difficulty bending at your knees
YES	NO	Difficulty squatting to the ground
YES	NO	Climbing a flight of stairs or a ladder carrying more than 25 lbs
YES	NO	Any other muscle or skeletal problem that interferes with using a respirator
15. What substances at your job are you exposed to or work around that cause you to wear a respirator? (For example: Paint vapors, Wood Dusts, Welding Fumes)		
YES	NO	**16. Would you like to talk with the physician about your answers to this questionnaire?**

EMPLOYEE SIGNATURE: ____ DATE: ________________