

**ANNUAL RESPIRATOR QUESTIONNAIRE**

**NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**HOME ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**COMPANY:** \_\_\_\_\_

**NUMBER YOU CAN BE REACHED AT BY HEALTH CARE PROFESSIONAL IF THEY HAVE QUESTIONS:** \_\_\_\_\_

**BEST TIME TO CALL:** \_\_\_\_\_

1. Have you developed any medical problems or symptoms that may limit your ability to use a respirator in the last year?

Yes No

2. Have you been told by a health care professional, your supervisor, or the respirator program administrator that you should be medically reevaluated in the last year?

Yes No

3. Have you developed any medical signs or symptoms related to respirator usage in the last year?

Yes No

4. Has there been a change in workplace conditions, e.g., physical work effort, protective clothing, temperature, that has resulted in a substantial increase in the physical burden on you within the last year?

Yes No

5. Have you had any changes in facial or neck structures (e.g. weight loss or scarring) within the last year?

Yes No

**Please explain any yes answers:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Employee Signature Date

**This form will be reviewed by** \_\_\_\_\_

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\_\_\_\_\_  
Licensed Healthcare Provider Signature Date

Comments