University Health Service

Medical Questionnaire for PAPR and N-95 Masks

Note to Evaluator: This questionnaire must be administered to employees in a way that ensures their understanding. Before asking the employee to fill out this questionnaire, please ask the following questions and record the employee's response.

Can you read English? ☐ Yes ☐ No	If you cannot read English, do you speak and understand English? ☐ Yes ☐ No

If the employee cannot read English, but understands and can speak English,_____or another evaluator who is not the employee's supervisor may ask the questions and document the employee's response. If the employee can neither read nor speak English, the evaluator must use an alternative method, suitable to the employee and the situation and document the method used. PLEASE PRINT LEGIBLY AND INCLUDE YOUR SS # AND/OR EMPLOYE ID NUMBER.

Name:	Employee ID:	Date of Birth:
Job Title:	Height: Weight:	Gender:
Department:	Work phone:	Home phone:

Question:

1. Have you had or do you have any of the following?
   a) Allergic reactions that interfere with breathing ..... Yes No
   b) Trouble smelling odors ..... Yes No
   c) Seizures (fits) ..... Yes No
   d) Diabetes (sugar disease) ..... Yes No
   e) Claustrophobia (fear of tight or enclosed spaces) ..... Yes No
2. Have you ever had any of the following lung problems?
   a) Asbestosis ..... Yes No
   b) Asthma ..... Yes No
   c) Chronic bronchitis ..... Yes No
   d) Emphysema ..... Yes No
   e) Pneumonia ..... Yes No
   f) Tuberculosis (TB) ..... Yes No
   g) Silicosis ..... Yes No
   h) Collapsed lung ..... Yes No
   i) Lung cancer ..... Yes No
   j) Broken ribs ..... Yes No
   k) Chest injuries or surgeries ..... Yes No
   l) Any other lung problem ..... Yes No
3. Do you have any of the following symptoms?
   a) Shortness of breath ..... Yes No
   b) Shortness of breath when walking fast on level ground or up a slight incline or hill.. ..... Yes No
   c) Shortness of breath when walking with other people at a normal 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 washing or dressing yourself ..... Yes No
   f) Shortness of breath that interferes with your job ..... Yes No
   g) Coughing that produces phlegm..... Yes No
   h) Coughing that wakes you up early in the morning..... Yes No
   i) Coughing that occurs mostly when you are lying down ..... Yes No
   j) Coughing up blood (within 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..... Yes No

(over)

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Form.Respirator fit
3/1/07
Rev AW/lm 7/3/07, LH 2/7/12, LH 7/5/12, LE 1/23/14, LE 12/24/15

4. Have you ever had any of the following cardiovascular or heart problems?
   a) Heart attack…… Yes No
   b) Stroke…… Yes No
   c) Angina …….. Yes No
   d) Swelling in your legs or feet…… Yes No
   e) Heart arrhythmia…… Yes No
   f) Any other heart problem …… Yes No
5. Have you had any of the following cardiovascular or heart symptoms?
   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) Heart skipping or missing a beat (within last two years) …… Yes No
   e) Heartburn or indigestion that is not related to eating…… Yes No
   f) Any other cardiovascular or circulatory problems…… Yes No
6. Do you currently take any medication for the following?
   a) Breathing or lung problems…… Yes No
   b) Heart trouble…… Yes No
   c) Blood pressure…… Yes No
   d) Seizures (fits) …… Yes No
7. Do you currently smoke or have you smoked within the last month? …… Yes No
8. Have your ever worn a respirator in the past? …… Yes No
9. If so, have you ever had any of the following during respirator use?
   a) Eye irritation…… Yes No
   b) Skin allergies or rashes…… Yes No
   c) Anxiety…… Yes No
   d) General weakness or fatigue…… Yes No
   e) Any other problem that would interfere with respirator use…… Yes No
10. Has your supervisor told you how to contact the safety officer (Sharon Berry) or health care provider who will review your evaluation …… Yes No
11. Would you like to talk to the health care provider who will review your evaluation about your answers to the questions? …… Yes No

Note: If the employee answered "Yes" to any part of questions 1-6 or 9, the evaluation must be reviewed by a licensed health care provider prior to granting approval for respirator use.

Evaluator Use Only	
☐ Approved	☐ Denied
☐ Approved with restrictions. List restrictions:	
Evaluator signature:	Evaluator Name (printed):

This medical evaluation has been developed in compliance with OSHA 1910.134, Appendix C.

Following a satisfactory fit testing for respirator use, the Health Care Worker was issued: *(check one)*

Date of test:_____

_____Tecnol Reg. N95 *(KC Clark)*

_____Tecnol Small N95*(KC Clark)*

_____3M N95 1860

_____3M N95 1860 Small

_____Test Failed , PAPR letter given

_____Unable to fit test due to beard or otherwise, PAPR letter given

_____Other, specify size and brand _____

Please send the completed forms to Leslie Ehrmantraut at University Health Service, room 404A. (Fax 257-9814)

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Rev AW/lm 7/3/07, LH 2/7/12, LH 7/5/12, LE 1/23/14, LE 12/24/15 ,
LE 11/30/16, LE 12/14/17