

Respirator Medical Evaluation

This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to wear a respirator. Fit test is also required. All medical information is considered confidential.

All information must be completed for respirator approval.

Name:	Date:	Employee Number # or EID:
Job/Title:	Unit/Department:	Manager:
Work Phone:	Home Phone:	
Work Location:		

	Yes	No
Have you ever used a respirator mask before?		
Have you ever had problems wearing a respirator?		
Do you have medical problems which may interfere with respirator use?		
Are you short of breath at rest?		
Do you get short of breath when walking?		
Do you get chest pain with certain activities?		
Do you have claustrophobia?		

Has a doctor ever told you, that you have one of the following?

	Yes	No		Yes	No
Angina			Diabetes		
Heart Attack			Lung Disease		
Heart Disease			Asthma		
Epilepsy or Seizure			High Blood Pressure		

Smoking History:

Smoke: _____ Ex-Smoker: _____ Never Smoker: _____

Are you currently taking any medications?

If yes please list: _____

Since facial hair may interfere with the respirator face piece seal, gentlemen need to be clean shaven while wearing any tight-fitting respirator. This includes disposable filtering face piece respirators such as N95s. Fit testing should be repeated if you have a weight change of 20 pounds (9.07kg) or more, significant facial scarring in the area of the face piece seal, significant dental changes (i.e. multiple extractions without prosthesis, or acquiring dentures), reconstructive or cosmetic surgery, or any other condition which may interfere with face piece sealing. I understand the above, and will schedule a new it test with Employee Health if indicated.

Employee Signature _____ Date: _____

Approved _____ Denied _____

Restrictions/Remarks _____