|  |
| --- |
| Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it. |

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Employee ID#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Contract**  **Doctor**

**Department/Agency**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Supervisor**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Job Title**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**\_\_\_\_\_/\_\_\_\_/\_\_\_\_ **Age**: \_\_\_\_\_\_\_ **Height**: \_\_\_\_\_\_\_\_ **Weight**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List ALL** **Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Please check the appropriate answers:** | | | **YES** | **NO** |
| **1.** | **Do you currently have facial hair other than a mustache? (If yes, complete questionnaire however, DO NOT mask fit)** | |  |  |
| **2.** | **Do you currently smoke tobacco, or have you smoked tobacco in the last month?** | |  |  |
| **3.** | Have you ever had any of the following conditions? | | | |
|  | A | Seizures (fits) |  |  |
|  | B | Diabetes (sugar disease) |  |  |
|  | C | Allergic reactions that interfere with your breathing |  |  |
|  | D | Claustrophobia (fear of closed-in places) |  |  |
|  | E | Trouble smelling odors |  |  |
| **4.** | Have you ever had any of the following pulmonary or lung problems? | | | |
|  | A | Asbestosis |  |  |
|  | B | Asthma |  |  |
|  | C | Chronic bronchitis |  |  |
|  | D | Emphysema |  |  |
|  | E | Pneumonia |  |  |
|  | F | Tuberculosis |  |  |
|  | G | Silicosis |  |  |
|  | H | Pneumothorax (collapsed lung) |  |  |
|  | I | Lung cancer |  |  |
|  | J | Broken ribs |  |  |
|  | K | Any chest injuries or surgeries |  |  |
|  | L | Any other lung problem |  |  |
| **5.** | Do you currently have any of the following symptoms of pulmonary or lung illness? | | | |
|  | A | Shortness of breath |  |  |
|  | B | Shortness of breath when walking fast on level ground or walking up a slight hill or incline |  |  |
|  | C | Shortness of breath when walking with other people at an ordinary pace on level ground |  |  |
|  | D | Have to stop for breath when walking at your own pace on level ground |  |  |
|  | E | Shortness of breath when washing or dressing yourself |  |  |
|  | F | Shortness of breath that interferes with your job |  |  |
|  | G | Coughing that produces phlegm (thick sputum) |  |  |
|  | H | Coughing that wakes you early in the morning |  |  |
|  | I | Coughing that occurs mostly when you are lying down |  |  |
|  | J | Coughing up blood in the last month |  |  |
|  | K | Wheezing |  |  |
|  | L | Wheezing that interferes with your job |  |  |
|  | M | Chest pain when you breathe deeply |  |  |
|  | N | Any other symptoms that you think may be related to lung problems |  |  |

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| **6.** | **Have you ever had any of the following cardiovascular or heart problems? YES NO** | | | |
|  | A | Heart attack |  |  |
|  | B | Stroke |  |  |
|  | C | Angina |  |  |
|  | D | Heart failure |  |  |
|  | E | Swelling in your legs or feet (not caused by walking) |  |  |
|  | F | Heart arrhythmia (heart beating irregularly) |  |  |
|  | G | High blood pressure |  |  |
|  | H | Any other heart problem |  |  |
| **7.** | **Have you ever had any of the following cardiovascular or heart symptoms?** | | | |
|  | A | Frequent pain or tightness in your chest |  |  |
|  | B | Pain or tightness in your chest during physical activity |  |  |
|  | C | Pain or tightness in your chest that interferes with your job |  |  |
|  | D | In the past two years, have you noticed your heart skipping or missing a beat |  |  |
|  | E | Heartburn or indigestion that is not related to eating |  |  |
|  | F | Any other symptoms that you think may be related to heart or circulation problems |  |  |
| **8.** | **Do you currently take medication for any of the following problems?** | | | |
|  | A | Breathing or lung problems |  |  |
|  | B | Heart trouble |  |  |
|  | C | Blood pressure |  |  |
|  | D | Seizures (fits) |  |  |
| **9.** | **Have you ever used a respirator/N-95 mask (if no go to question 12)** | |  |  |
| **10.** | **If you’ve used a respirator/N-95 mask, have you ever had any of the following problems?** | | | |
|  | A | Eye irritation |  |  |
|  | B | Skin allergies or rashes |  |  |
|  | C | Anxiety |  |  |
|  | D | General weakness or fatigue |  |  |
|  | E | Any other problem that interferes with your use of a respirator |  |  |
| **11.** | **Would you like to talk to the health care professional that will review this questionnaire?** | |  |  |

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| **Disclaimer**  Fit testing, as performed, measures the ability of the respiratory protective device to provide protection to the individual tested. Neither the Employee Occupational Health Department nor the test conductor make any guarantee that this or an identical respiratory protective device will provide adequate protection under conditions other than those present when this test was performed. Improper use, maintenance, or application of this or any other respiratory protective device will reduce or eliminate protection.  **Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

**Please send this completed form by interdepartmental mail to EOH at your local facility.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Medical Department Use Only | Fit Test: Approved  Denied  Additional evaluation needed  Annual education provided | | | | | | | | |
|  | Remarks: | | | | | | | | |
|  | | | | | | | | |
| Reviewed by: |  | | Date: |  | / |  | / |  |
| Remarks: | | | | | | | | |
|  | | | | | | | | |
| Physician Review (if indicated) by: | |  | Date: |  | / |  | / |  |