N-95 RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

DATE_________LAST NAME______________FIRST NAME______________

AGE _______ WT _______ HT _______ SOCIAL SECURITY # _______ - _______ - _______

DEPARTMENT_______________________DAYTIME PHONE _______________________

Please circle correct answer.

1. Do you currently smoke tobacco or have you smoked tobacco in the past month: Y N

2. Have you ever had any of the following conditions?
   a. Seizures: Y N
   b. Diabetes: Y N
   c. Allergic reactions that interfere with your breathing: Y N
   d. Claustrophobia: Y N
   e. Trouble smelling odors: Y N

3. Have you ever had any pulmonary or lung problems? Y N
   If yes, please describe:____________________________________________________

4. Do you currently have any of the following pulmonary symptoms?
   a. Shortness of breath: Y N
   b. Coughing: Y N
   c. Wheezing: Y N
   d. Chest pain: Y N
   If yes, please describe:____________________________________________________

5. Have you ever had any cardiovascular or heart problems? Y N
   If yes, please describe:____________________________________________________

6. Have you ever had any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest: Y N
   b. Pain or tightness in your chest during physical activity: Y N
   c. Pain or tightness in your chest that interferes with your job: Y N
   d. In the past 2 years, have you noticed your heart skipping or missing a beat: Y N
   e. Heartburn or indigestion that is not related to eating: Y N
   f. Any other symptoms possibly related to heart or circulation problems: Y N
   If yes, please describe:____________________________________________________

7. Do you currently take medication for any of the following problems?
   a. Breathing or lung problems: Y N
   b. Heart trouble: Y N
   c. Blood pressure: Y N
   d. Seizures: Y N

8. Have you ever worn a respirator? Y N
   If yes: what type? ________________________________________________________

9. If you have used a respirator, have you ever had any of the following problems?
   a. Eye irritation: Y N NA
   b. Skin allergies: Y N NA
   c. Anxiety: Y N NA
   d. General weakness or fatigue: Y N NA
   e. Any other problem that interferes with your use of a respirator Y N NA
LAST NAME ___________________________ FIRST NAME ___________________________

================================================================================================================================

FOR PLHCP (Physician/Nurse) USE ONLY

Type of respirator: N-95

Approved to wear respirator: YES NO

Requires further evaluation: YES NO

Restrictions/Limitations: ________________________________

Date: ___________________________ (PLHCP signature)