

## RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

This form is used to determine whether or not you have a medical condition that may affect your ability to wear a respirator. The form must be completed in full and will be reviewed by University Health Services. If you have any questions regarding this information, please contact UHS at (215) 955-6835. Your health information will remain confidential. All completed forms will be maintained in your UHS medical record only.

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ MALE FEMALE

BEST TIME TO PHONE: \_\_\_\_\_

JOB TITLE/DEPT: \_\_\_\_\_ Extension: \_\_\_\_\_

Please circle one: Jefferson Employee Agency/Traveler Jefferson Student – Program: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you worn a respirator in the past? Yes No

**IF YES, WHAT TYPE?** \_\_\_\_\_

Have you been fit tested at Jefferson in the past? Yes No

**IF NO, PLEASE PROCEED TO SECTION A AND COMPLETE BOTH SIDES OF THE FORM.**

If you have been fit tested at Jefferson in the past, have you had any significant changes in your health since your last fit test?

Yes No

**IF NO, PLEASE SIGN BELOW AND GIVE THIS FORM TO UNIVERSITY HEALTH SERVICES.**

**IF YES, PLEASE PROCEED TO SECTION A , COMPLETE BOTH SIDES OF THE FORM, AND GIVE THIS FORM TO UNIVERSITY HEALTH SERVICES.**

I verify by my signature below that the above statements are true to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

### SECTION A

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes No
2. Please check below if you have ever had any of the following conditions:
  - Seizures
  - Diabetes
  - Allergic reactions that interfere with your breathing
  - Claustrophobia
  - Trouble smelling odors
3. Please check below if you have ever had any of the following pulmonary or lung problems:
  - Asbestosis
  - Asthma
  - Chronic bronchitis
  - Emphysema
  - Pneumonia
  - Tuberculosis
  - Silicosis
  - Pneumothorax (collapsed lung)
  - Lung cancer
  - Broken ribs
  - Any chest injuries or surgeries
  - Any other lung problem that you've been told about

Description: \_\_\_\_\_
4. Please check below if you currently have any of the following symptoms of pulmonary or lung illness:
  - Shortness of breath
  - Shortness of breath when walking fast on level ground or walking up a slight hill or incline
  - Shortness of breath when walking with other people at an ordinary pace on level ground

- Shortness of breath when walking at your own pace on level ground
- Have to stop for breath when walking at your own pace on level ground
- Shortness of breath when washing or dressing yourself
- Coughing that produces phlegm (thick sputum)
- Coughing that wakes you early in the morning
- Coughing that occurs mostly when you are lying down
- Coughing up blood in the last month
- Wheezing
- Wheezing that interferes with your job
- Chest pain when you breathe deeply
- Any other symptoms that you think may be related to lung problems

Description: \_\_\_\_\_

5. Please check below if you have ever had any of the following cardiovascular or heart problems:

- heart attack
- stroke
- angina
- heart failure
- swelling in your legs or feet (not caused by walking)
- heart arrhythmia (heart beating irregularly)
- high blood pressure
- any other heart problem that you've been told about

Description: \_\_\_\_\_

6. Please check below if you have ever had any of the following cardiovascular or heart symptoms:

- frequent pain or tightness in your chest
- pain or tightness in your chest during physical activity
- pain or tightness in your chest that interferes with your job
- in the past two years, have you noticed your heart skipping or missing a beat
- heartburn or indigestion that is not related to eating
- any other symptoms that you think may be related to heart or circulation problems

Description: \_\_\_\_\_

7. Do you currently take medications for any of the following problems?

- breathing or lung problems
- heart trouble
- blood pressure
- seizures

8. Please check below if you've used a respirator and have had any of the following problems:

- eye irritation
- skin allergies or rashes
- anxiety
- general weakness or fatigue
- any other problem that interferes with your use of a respirator

Description: \_\_\_\_\_

9. Would you like to talk to the UHS clinician who will review this questionnaire about your answers to this questionnaire? Yes No

I verify by my signature below that the above statements are true to the best of my knowledge.

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

.....  
To be completed by UHS Personnel

\_\_\_\_\_ approved for fit testing      \_\_\_\_\_ denied      \_\_\_\_\_ approved with restrictions

\_\_\_\_\_  
UHS Personnel Date

# Respirator Evaluation/Fit Testing Form

Today's date: \_\_\_\_\_

This form certifies that University Health Services (UHS) has completed a Respirator Medical Evaluation Questionnaire for the following employee/student:

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ DEPT/UNIT: \_\_\_\_\_

The employee/student is: \_\_\_\_\_ approved for fit testing  
\_\_\_\_\_ approved with restrictions:  
\_\_\_\_\_ not approved for fit testing

\_\_\_\_\_  
UHS Clinician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

.....  
Date of Fit Testing: \_\_\_\_\_

Type & Size of Respirator: \_\_\_\_\_

Certified Trainer's Name: \_\_\_\_\_

Certified Trainer's Signature: \_\_\_\_\_

**PLEASE COMPLETE THIS FORM, MAINTAIN A COPY IN THE PERSONNEL FILE AND RETURN THE ORIGINAL TO UNIVERSI**