University of Massachusetts Medical School Respirator Fitness Determination

Name: _____

Graduating Class: _____ Date of Birth _____/____/_____

Questionnaire to determine fitness to wear a NIOSH approved respirator. Please check each item **YES** or **NO**. If you check **YES**, please provide an explanation. All questions must be answered**.**
Any questions can be addressed to Student Health Services @ studenthealth@ummhc.org

1. Have you worn a respirator before? _____ No _____ Yes
   (what type/for what purpose?)_____
2. Have you had problems wearing a respirator? _____ No _____ Yes Explain_____
3. Do you have claustrophobia or anxiety problems that would make wearing a mask difficult for you? ____No____Yes
4. Do you have a beard or mustache? _____ No _____Yes Explain_____
5. Do you have problems with your sense of smell? _____ No _____Yes Explain_____
6. Do you have skin allergies? Other allergies? ____ No ____ Yes Explain_____
7. Do have any heart problems? (Angina, heart failure**)?**____ No ____ Yes Are you symptomatic…edema, shortness of breath. _____
8. Do you have any lung disease (chronic cough, emphysema, asthma, infections, bronchitis)?___No___Yes
   Are you symptomatic _____ Are you well controlled on medication? _____
9. Do you smoke? _____ No _____ Yes How many packs per day?____ How many years?_____
   Are you symptomatic with respiratory problems?_____
10. Do you have seizures? _____ No _____ Yes Are you well controlled on medication?_____
11. What prescription medications are you taking?
    _____ _____ _____ _____

Student Signature: _____ Date:_____

Return the completed form to:

Student Health,
University of Massachusetts Medical School,
55 Lake Avenue North, Worcester, MA 01655

Student Health Services Use Only:

_____ Approved for PAPR
_____ Approved for tuberculosis respirator N-95 Mask
_____ Awaiting further data, on medical hold
_____ Not approved for respirator use

Revised 10/2008 Date:_____ Ext. _____

Attachment to 1st e-mail