

**Ottumwa Regional Health Center
Respiratory / Mask Fit Questionnaire**

Name _____ SS# _____ DOB _____

Department _____ Position _____ Date _____

WORK HISTORY

Work requiring you to wear a respirator / mask, please **Check One:**

Light _____ 1 hour or less Moderate _____ 1-5 hours per shift Heavy _____ 5-12 hours

MEDICAL HISTORY

HAS A PHYSICIAN EVER TOLD YOU THAT YOU HAVE HAD ANY OF THE FOLLOWING?

Emphysema or Asthma	Y or N	Persistent Cough	Y or N
Chest Pain	Y or N	Shortness of Breath	Y or N
High Blood Pressure	Y or N	Claustrophobia	Y or N
Sensation of Smothering	Y or N	HX of fainting	Y or N
HX of Seizures	Y or N	Contact Lenses	Y or N
Glasses	Y or N		

Other Conditions that might interfere with respiratory use or limited work ability _____

Do you have sensitivity to any of the following: Rubber bands, rubber gloves, tape, rubber balloons, bananas, kiwi fruit, poinsettias, and clothing with elastic? *Circle any that apply.*

Explain yes answers _____

Signature _____ **Date** _____

FIT TEST RECORD

Conditions that may affect respirator/mask fit.

Clean Shaven _____ 1-2 day growth _____ 2+ day growth _____ Mustache _____

Facial Scars _____ Dentures _____ Dentures Absent _____ Glasses _____

Other _____ None _____ Comments _____

Employee acknowledgement of familiarity with user instructions and certain limitations.

I understand the instructions of the N95 hepa-respirator and will follow those instructions every time I use the respirator. I acknowledge that this respiratory protective device will not provide adequate protection when used under conditions other than specified or when proper use instructions are not followed.

Employee Signature _____ **Date** _____

Fit Test Results

The fit test procedure was conducted in fulfillment of ORSHA'S fit testing requirements of employees wearing half mask respirators (code of federal regulations 29 CFR 1910.134 e 5) and in accordance with American national Standard Institute Practices for Respiratory Protection, ANSI Z88.21-992.

Fit Test Type Qualitative Y or N Agent _____
Mask Size _____ Type _____ Employee Status Pass _____ Fail _____

Employee's acknowledgement of test results-

Employee Signature _____ **Date** _____

Test Conductors Signature _____ **Date** _____

Respiratory referral made to a physician _____

Specific Restrictions _____

Restriction set by _____ Date _____