



# N95 Respiratory Fit Testing Questionnaire

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Department: \_\_\_\_\_ Job title: \_\_\_\_\_ Last 4 SS# \_\_\_\_\_

**The following information must be provided by every employee who has been selected to use any type of respirator (please print).**

Do you usually use an N95 mask (no facial hair) or PAPR (facial hair)?    Mask                  PAPR

Appendix C to Sec 1910.134: OSHA Respirator Evaluation Questionnaire (Mandatory)

**To the Employer:** Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

**To the employee:** Your employer must allow you to answer the questionnaire during normal working hours, or at a time and place 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.

**Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").**

	YES	NO
1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you <i>ever had</i> any of the following conditions?		
a. Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease).....	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Claustrophobia (fear of closed-in places).....	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble smelling odors.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you <i>ever had</i> any of the following pulmonary or lung problems?		
a. Asbestosis.....	<input type="checkbox"/>	<input type="checkbox"/>
b. AsthmaChronic bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Pneumonia.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Silicosis.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Pneumothorax (collapsed lung).....	<input type="checkbox"/>	<input type="checkbox"/>
h. Lung cancer.....	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
i. Broken ribs.....	<input type="checkbox"/>	<input type="checkbox"/>
j. Any chest injuries or surgeries.....	<input type="checkbox"/>	<input type="checkbox"/>
k. Any other lung problem that you've been told about.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you <i>currently</i> have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath when walking with other people at an ordinary pace on level ground.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Have to stop for breath when walking at your own pace on level ground.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Shortness of breath when washing or dressing yourself.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Shortness of breath that interferes with your job.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Coughing that produces phlegm (thick sputum).....	<input type="checkbox"/>	<input type="checkbox"/>
h. Coughing that wakes you early in the morning.....	<input type="checkbox"/>	<input type="checkbox"/>
i. Coughing that occurs mostly when you are lying down.....	<input type="checkbox"/>	<input type="checkbox"/>
j. Coughing up blood in the last month.....	<input type="checkbox"/>	<input type="checkbox"/>
k. Wheezing.....	<input type="checkbox"/>	<input type="checkbox"/>
l. Wheezing that interferes with your job.....	<input type="checkbox"/>	<input type="checkbox"/>
m. Chest pain when you breathe deeply.....	<input type="checkbox"/>	<input type="checkbox"/>
n. Any other symptoms that you think may be related to lung problems.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you <i>ever had</i> any of the following cardiovascular or heart problems?		
a. Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Angina.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Heart failure.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Swelling in your legs or feet (not caused by walking).....	<input type="checkbox"/>	<input type="checkbox"/>
f. Heart arrhythmia (heart beating irregularly).....	<input type="checkbox"/>	<input type="checkbox"/>
g. High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
h. Any other heart problem that you've been told about.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain or tightness in your chest during physical activity.....	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
c. Pain or tightness in your chest that interferes with your job.....	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past two years, have you noticed your heart skipping or missing a beat.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Heartburn or indigestion that is not related to eating.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you <i>currently</i> take medication for any of the following problems?		
a. Breathing or lung problems.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
8. If you've used a respirator, have you <i>ever had</i> any of the following problems? (If you've never used a respirator, check the following space and go to question 9.) <input type="checkbox"/>		
a. Eye irritation.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin allergies or rashes.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>
d. General weakness or fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Any other problem that interferes with your use of a respirator.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?.....	<input type="checkbox"/>	<input type="checkbox"/>

**Please answer the following additional questions and sign the acknowledgement on the following page:**

	YES	NO
1. Do you have chronic bronchitis or asthma that interferes with the use of a mask or respirator?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. If you have asthma, have you ever had breathing problems when wearing a mask or respirator?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any medical problems that might interfere with the use of a mask or respirator?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a history of high blood pressure, cerebral or coronary vessel disease, congestive heart disease, or COPD?.....	<input type="checkbox"/>	<input type="checkbox"/>

## ACKNOWLEDGEMENT

The N95 respirator is to be used when entering the room of a patient on Airborne Precautions. The N95 respirator fits tightly and restricts air intake, and therefore requires medical clearance for both fit testing and use. Powered air-purifying respirators (PAPRs) are available for staff who has not been fit tested for the N95 respirator. Males must be clean-shaven when they are fit, and any beard growth will affect the fit of the respirator. If you lose or gain 20 pounds or more, or have dental/facial trauma or surgery, you should come to Health Service for an evaluation of your respirator fit.

A user seal check is a procedure conducted by the respirator wearer to determine if the respirator is being properly worn. The user seal check can either be a positive pressure or negative pressure check. During a positive pressure user seal check, the respirator user exhales gently while blocking the paths for air to exit the facepiece. A successful check is when the facepiece is slightly pressurized before increased pressure causes outward leakage. During a negative pressure user seal check, the respirator user inhales sharply while blocking the paths for air to enter the facepiece. A successful check is when the facepiece collapses slightly under the negative pressure that is created with this procedure. A user seal check is sometimes referred to as a fit check. A user seal check should be completed each time the respirator is donned (put on). It is only applicable when a respirator has already been successfully fit tested on the individual.

**\*IF YOU HAVE A HISTORY OF HIGH BLOOD PRESSURE YOU MUST COME TO HEALTH SERVICE FOR A BLOOD PRESSURE CHECK OR PROVIDE A RECENT BLOOD PRESSURE READING BELOW.**

I understand that I have been cleared for use of an N95 respirator or PAPR hood. I am aware that I should wear this personal protective equipment (PPE) whenever I am in a room with a patient on airborne precautions, or in an area where there are laboratory animals. I am aware that I should wear only the brand/size with which I have been fit-tested. I understand that a PAPR hood cannot be used in the OR or in any sterile field.

Respirator User Signature or E-Signature: \_\_\_\_\_ Date: \_\_\_\_\_

After completing the form electronically, please e-mail to e-mail distribution group:  
Employee Health Services (EmployeeHealthUsers@saratogahospital.org).

If printed, please send completed form:

- Via interoffice mail to the Saratoga Hospital Employee Health Office, or
- Fax to Attention of Employee Health Office (518-583-8403), or
- Scan and e-mail the form to Employee Health Services (EmployeeHealthUsers@saratogahospital.org).

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### EMPLOYEE HEALTH OFFICE USE ONLY:

Cleared for N95 fit test and use of the N95 respirator or PAPR:    Yes                      No

EHO Review by: \_\_\_\_\_ Date: \_\_\_\_\_

Signature or E-Signature