Emergency Management Associates

N95 Respirator Training Medical Questionnaire

Please print all information clearly and legibly.

Name of Educational Institution:	
Name(last name, first name)	Today's date:

1. Have you ever worn a respirator? ☐ Yes ☐ No
   - If yes, check which type(s) ☐ Dust mask (N95) ☐ Cartridge
2. If yes to the above, have you had any difficulties using the respirator? ☐ Yes ☐ No
   - Eye irritation ☐ Yes ☐ No
   - Skin irritation or rash ☐ Yes ☐ No
   - If Yes, please describe:_____
3. Do you have trouble tasting? ☐ Yes ☐ No
4. Do you have asthma? ☐ Yes ☐ No
   (if you take medication for asthma, please bring it with you to the fit testing)
5. Do you have any other lung or breathing problems? ☐ Yes ☐ No
   - If Yes, please describe:_____
6. (a) Do you have any of the following medical conditions that might interfere with use of a mask?
   ☐ Diabetes Mellitus ☐ Epilepsy or seizure disorder ☐ High blood pressure
   ☐ History of fainting ☐ Heart problems ☐ Other: _____

   (b) Besides the medical conditions listed in 6(a), are you taking a prescription and/or over the counter medication with full symptoms that may interfere with wearing a mask, as: ☐ Yes ☐ No
   Shortness of breath, Breathing difficulties, Heart problems, Chest pain, Light headedness or Blackouts
7. Have you had allergic reactions that interfere with your breathing? ☐ Yes ☐ No
8. Do you have:
   - latex sensitivity ☐ Yes ☐ No
   - latex allergy ☐ Yes ☐ No
   - other allergies ☐ Yes ☐ No

I affirm that the above information is true and factual:

Signature: Date: _____/_____/_____

DO NOT WRITE BELOW --- OFFICE USE ONLY

☐ Cleared for fit test

Sensitivity test: ☐ Pass ☐ Fail
Solution: ☐ Sweet ☐ Bitter
Test: ☐ 30 ☐ 45 ☐ 60

Tester:_____

Fit test: ☐ Pass ☐ Fail – *Reason: ☐ Facial hair ☐ Other*:_____