MEDICAL EVALUATION AND QUESTIONNAIRE
N95 RESPIRATOR FIT TESTING

Today's Date:__________________

Name	Last, First:	Date of Birth:	Phone Number:
(Please Print)	Department	Job Title/College Year ☐	

Have you ever worn a respirator before?	☐ YES [Size] __________________ ☐ NO
Do you NORMALLY wear a Beard?	☐ YES ☐ NO

Have you ever had any of the following conditions?	Yes	No	Comment
1. Allergic reactions that interfere with your breathing?			
2. Shortness of breath without exertion?			
3. Seizures?			
4. Persistent cough?			
5. Chronic Bronchitis or Emphysema?			
6. Asthma or Wheezing?			
7. Tuberculosis?			
8. Lung Cancer?			
9. Chest injury or surgery; Broken Ribs			
10. Pneumothorax?			
11. Chest pain or tightness?			
12. Heart disease or Irregular Heartbeat?			
13. Claustrophobia (fear of tight or enclosed spaces)?			
14. Allergy to Saccharin or Bitrex?			
15. Had significant facial surgery?			
16. Other problems that may interfere with wearing a respirator?			
Signature of Respirator User			

Medical Clearance: Licensed Medical Healthcare Professional *(check the element that represents your recommendation):*

	Fit for respirator use with no restrictions
	Fit for respirator use with mild restrictions or accommodations (see comments below):
	Additional testing is needed before fitness can be determined
	Not fit for respirator use

Signature/Date of Healthcare Professional	

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