Respiratory Protection Health Screening Questionnaire

Name (Please print): _____ ***Phone Ext.*** _____

Unit/Dept: _____ ***Job Title:*** _____ ***Supervisor:*** _____

The use of a N-95 Respirator Mask is intended to provide additional protection from exposure to agents that cause disease via the airborne route, e.g., Active Tuberculosis (TB) Disease, Chickenpox (Varicella), Measles. Respiratory protection is a requirement for all Healthcare Providers during the care of a patient who requires AIRBORNE ISOLATION PRECAUTION; the requirement is in accordance with the Occupational Safety and Health Administration (OSHA) 1910.134
This health-screening questionnaire helps identify healthcare workers who have pulmonary, cardiac or other conditions that may preclude them from the use of a N-95 Respirator Mask. This form is confidential.
Return to Infection Prevention in an envelope.

Age: ___ ***Gender:*** ***Smoker: Yes/No***

Please circle all that apply: Beard/ Mustache/ glasses

Have you had or do you currently have any of the following (check box):

	Yes	No	Is the condition current?	Is it controlled with medication?
1. Lung Disease (e.g., Chronic Bronchitis, Emphysema, Asthma, Pneumonia, TB)				
2. Shortness of Breath (during non-strenuous activities, routine activity)				
3. Persistent Cough (Not related to smoking/simple cold/seasonal allergies)				
4. Allergic Reactions that interfere with your breathing (Seasonal or _____ aller				
5. Heart Trouble/Disease (e.g., Irregular Heart Beat, Angina, Stroke, Chest pain, High blood ressure				
6. Nose, throat or sinus trouble?				
7. Feelings of Claustrophobia (fear of closed-in places)				
a. Would this stop you from wearing a respirator for 30 minutes?				
8. Do you have any other medical condition that YOU FEEL may preclude you from wearing a N-95 Respirator? If **YES**, please specify:				
9. Are you currently taking medication for any of the following conditions: breathing/lung problems, heart trouble, blood pressure, seizures? ⇒ If **YES**, indicate if the condition is controlled with these medications:				
10. Have you worn a respirator in the past?				
⇒ If yes, what type?				
⇒ Any problems with use?				
11. Would you like to communicate with the healthcare professional who will review this form?				

Employee's signature denotes agreement: I understand that this clearance for N95 respirator use is based on my current medical condition. In the event my medical condition changes, I agree to notify my supervisor for re-evaluation.

Employee Signature: _____ Date: _____

Medical Clearance for N-95/PAPR: ***Yes*** ____ (No apparent contraindication noted) ***No*** ____ (Reason noted)

Medical Reviewer: _____ RN/MD Date: _____