Respiratory Fit Test Report

Qualitative Respirator Fit Test Record

Student Name:	**Student ID Number:**
Course:	**Date:**

☐ I have previously completed a medical questionnaire and have not had any significant changes in my medical status or physical appearance (such conditions include but are not limited to, facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight) that could affect respirator fit. If you have had any of the above changes, STOP here and complete a questionnaire before proceeding with fit test.

Sensitivity Threshold Testing Results:

Saccharin	☐ Pass x Squeezes	☐ Fail
Bitrex	☐ Pass x Squeezes	☐ Fail

Mask Fitting:

Action	**Mask #1:**		**Mask #2:**		**Mask #3:**		**Mask #4:**	
Normal Breathing	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail
Deep Breathing	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail
Turning Head side to side	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail
Moving head up and down	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail
Talking	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail
Bending Over	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail
Normal Breathing	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail

Overall Fit Test Results:		
KC/Halyard Regular: Pass Fail	KC/Halyard Small: Pass Fail	3M 1870: Pass Fail
3M 1860: Pass Fail	3M 1860 Small: Pass Fail	3M 8210: Pass Fail
Moldex 7801 Small: Pass Fail	Moldex 7802 Medium: Pass Fail	Moldex 7803Large: Pass Fail
Other:	Failure due to:	

☐An attempt to fit me for a respirator was successful. I understand that the fit test is valid for one year and will expire on _____ I understand that I must complete fit test annually.

☐I have been fitted for a respirator mask. I have been instructed on the proper use and storage of the respirator mask. I have also been instructed on when the respiratory mask must be replaced> I will follow all OSHA standards and regulations when wearing this type of respirator.

☐ An attempt to fit me for the respirator was unsuccessful. I understand I will NOT be able to enter a room requiring the use of a respiratory mask.

Signature:	**Date:**
Test Conducted By (Signature):	**Date:**
Test Conducted By (Print Name):	**Fit Test ID Number:**

N-95 Respiratory Clearance Questionnaire

N-95 Respiratory Clearance Questionnaire

A. This section is used in determining whether or not you have a medical condition that may affect your ability to safely wear a respirator.

B. We anticipate being able to approve most people for respirator use based on this questionnaire.

C. In some cases, we may ask for more information or additional medical testing/ evaluation. Fit testing is also required and is done separately.

Part A- Section 1

Date	Printed Name	Date of Birth
Age	Sex ☐ Male ☐ Female	Height ft. in.	Weight lb.
Title		
Phone Number For review of this Questionnaire if need	Best time to reach you	

This Questionnaire is being administered in regards to the N-95 Respirator

Part A- Section 2

1. Smoking History
☐ Current ☐ Past Month ☐ Never

2. Have you **ever had** any of the following:
☐ Seizures ☐ Diabetes
☐ Allergic reaction interfering with breathing
☐ Claustrophobia (fear of closed-in spaces)
☐ Trouble smelling odors

3. Have you **ever had** any of the following:
☐ Asbestosis ☐ Silicosis ☐ Chronic Bronchitis
☐ Lung Cancer ☐ Broken Ribs ☐ Emphysema
☐ Pneumonia ☐ Tuberculosis ☐ Pneumothorax
☐ Asthma List Asthma Triggers/ Controls
_____
☐ Any chest injury or surgery
☐ Any other lung problems you know of

4. Do you currently have any of the following:

Shortness of Breath
☐ Walking Fast ☐ Walking on an Incline
☐ Walking at an Ordinary Pace on Level Ground
☐ When Washing or Dressing Yourself
☐ That Interferes with Your Job

Coughing
☐ Produces Phlegm ☐ Wakes you in the Early Morning
☐ Occurs Mostly When Lying Down
☐ Blood in the Last Month

Wheezing
☐ That Interferes with Your Job ☐ Other

Other Pulmonary/ Lung Illness
☐ Chest Pain when Breathing Deeply
☐ Other Symptoms that may be Related

5. Have you **ever had** any of the following:
☐ Heart Attack ☐ Heart Failure
☐ Stroke ☐ Irregular Heart Beat
☐ Angina ☐ High Blood
☐ Pressure Swelling in Your Legs/ Feet
☐ Any other heart problems you know of

6. Have you **every had** any of the following:

Pain or Tightness in Your Chest
☐ Frequent ☐ During Physical Activity
☐ That Interferes with Your Job

History of
☐ In Past 2 years, Your Heart Skipping/ Missing Beats
☐ Heartburn/ Indigestion Not Related to Eating
☐ Other Symptoms that may be Related

7. Do you **currently** take Medications for the following:
☐ Heart Trouble ☐ Blood Pressure
☐ Seizures ☐ Breathing / Lung Problems
List Medications/ Reasons:
_____
_____
☐ Other Reasons List Medications/ Reasons:
_____

8. Have you used a Respirator (N-95 Mask)? ☐ Yes ☐ No
If Yes, have you had any of the following:
☐ Eye Irritation ☐ Skin Allergies/ Rashes
☐ Anxiety ☐ General Weakness/ Fatigue
☐ Other Problems that Interfere with Your Use

9. ☐ I would like to speak with the health care professional who will be reviewing this questionnaire

X _____
Student's Signature Date