

University of Massachusetts Medical School
Respirator Fitness Determination

Name: _____

Graduating Class: _____ Date of Birth ____/____/____

Questionnaire to determine fitness to wear a NIOSH approved respirator. Please check each item **YES** or **NO**. If you check **YES**, please provide an explanation. All questions must be answered.

Any questions can be addressed to Student Health Services @ studenthealth@ummh.org

1. Have you worn a respirator before? ____ No ____ Yes
(what type/for what purpose?) _____
2. Have you had problems wearing a respirator? ____ No ____ Yes Explain _____
3. Do you have claustrophobia or anxiety problems that would make wearing a mask difficult for you? ____ No ____ Yes
4. Do you have a beard or mustache? ____ No ____ Yes Explain _____
5. Do you have problems with your sense of smell? ____ No ____ Yes Explain _____
6. Do you have skin allergies? Other allergies? ____ No ____ Yes Explain _____
7. Do have any heart problems? (Angina, heart failure)? ____ No ____ Yes Are you symptomatic...edema, shortness of breath. _____
8. Do you have any lung disease (chronic cough, emphysema, asthma, infections, bronchitis)? ____ No ____ Yes
Are you symptomatic _____ Are you well controlled on medication? _____
9. Do you smoke? ____ No ____ Yes How many packs per day? ____ How many years? ____
Are you symptomatic with respiratory problems? _____
10. Do you have seizures? ____ No ____ Yes Are you well controlled on medication? _____
11. What prescription medications are you taking?

Student Signature: _____ Date: _____

Return the completed form to: STUDENTHEALTH@UMASSMEMORIAL.ORG

Student Health Services Use Only:

_____ Approved for PAPR

_____ Approved for tuberculosis respirator N-95 Mask

_____ Awaiting further data, on medical hold

_____ Not approved for respirator use