The University of Texas Rio Grande Valley

N95 RESPIRATOR USER QUESTIONNAIRE

INSTRUCTIONS: Your supervisor must allow you to answer this questionnaire at a time and place that is convenient to you. To maintain your confidentiality, your PI/HR-A/supervisor must not look at or review your answers. Please email completed form to ehsrm@utrgv.edu, where it will be reviewed by a health care professional and kept in your confidential medical record.

Name (Last, First, Middle Initial)	Sex (M/F)	Age	Today's date
Job Title	Height (ft. in.)	Weight (lbs)	Employee ID# / Student ID#

UTRGV Email address	Phone number where you can be reached
Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): ☐ Yes ☐ No	Best time(s) to contact you at this number

Check the type of respirator you will use (you can check more than one category):

a) ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
b) ☐ Other type (half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

Have you worn a respirator (circle one): ☐ Yes ☐ No
If "yes," what type(s):

Supervisor's Name / Professor's Name	Supervisor's email address

A. MEDICAL HISTORY *(Employee / Student completes)*

Please explain all 'Yes' answers below. Mandatory Questions 1 through 9 below must be answered by every employee / student who has been selected to use any type of respirator.

Yes	No	1. Do you *currently* or have you
☐	☐	Smoke tobacco or smoked tobacco in the last month

Yes	No	2. Have you *ever had* any of the following
☐	☐	Seizures
☐	☐	Diabetes (sugar disease)
☐	☐	Allergic reaction that interferes with your breathing
☐	☐	Claustrophobia (fear of closed-in places)
☐	☐	Trouble smelling odors

Yes	No	3. Have you *ever had* any of the following pulmonary or lung problems?
☐	☐	Asbestosis
☐	☐	Asthma
☐	☐	Chronic Bronchitis
☐	☐	Emphysema
☐	☐	Pneumonia
☐	☐	Tuberculosis
☐	☐	Silicosis
☐	☐	Pneumothorax (collapsed lung)
☐	☐	Lung Cancer
☐	☐	Broken Ribs
☐	☐	Any chest injuries or surgeries
☐	☐	Any other lung problem that you've been told about

Yes	No	4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
☐	☐	Shortness of breath
☐	☐	Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐	☐	Shortness of breath when walking with other people at an ordinary pace on level ground
☐	☐	Have to stop for breath when walking at your own pace on level ground
☐	☐	Shortness of breath when washing or dressing yourself
☐	☐	Shortness of breath that interferes with your job
☐	☐	Coughing that produces phlegm (thick sputum)
☐	☐	Coughing that wakes you early in the morning
☐	☐	Coughing that occurs mostly when you are lying down
☐	☐	Coughing up blood in the last month
☐	☐	Wheezing
☐	☐	Wheezing that interferes with your job
☐	☐	Chest pain when you breathe deeply
☐	☐	Any other symptoms that you think may be related to lung problems

Yes	No	5. Have you *ever had* any of the following cardiovascular or heart problems?
☐	☐	Heart attack
☐	☐	Stroke
☐	☐	Angina
☐	☐	Heart failure
☐	☐	Swelling in your legs or feet (not caused by walking)
☐	☐	Heart arrhythmia (heart beating irregularly)
☐	☐	High Blood Pressure
☐	☐	Any other heart problem that you've been told about

Yes	No	6. Have you *ever had* any of the following cardiovascular or heart symptoms?
☐	☐	Frequent pain or tightness in your chest
☐	☐	Pain or tightness in your chest during physical activity
☐	☐	Pain or tightness in your chest that interferes with your job
☐	☐	In the past two years, have you noticed your heart skipping or missing a beat
☐	☐	Heartburn or indigestion that is not related to eating
☐	☐	Any other symptoms that you think may be related to heart or circulation problems

Yes	No	7. Do you *currently* take medication for any of the following problems?
☐	☐	Breathing or lung problems
☐	☐	Heart trouble
☐	☐	Blood pressure
☐	☐	Seizures

Yes	No	8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9) ☐
☐	☐	Eye irritation
☐	☐	Skin allergies or rashes
☐	☐	Anxiety
☐	☐	General weakness or fatigue
☐	☐	Any other problem that interferes with your use of a respirator

Explain all 'Yes' answers here:
What medications, if any, do you use for problems with your nose, sinuses, throat, lungs, breathing or heart function?
9. Would you like to speak with a health care professional about any of your answers to this questionnaire? ☐ **Yes** ☐ **No**

The preceding information is true to the best of my knowledge.

_____ _____

Employee's / Student's Signature **Date**

B. MEDICAL CLEARANCE *(Physician or other Licensed Health Care Provider completes)*

Medical Clearance for use of an N95 respirator in a clinical care setting:

☐ **Approved** ☐ **Approved with restrictions** ☐ **Denied**

Remarks

Reviewed by: _____ _____

Clinician Name/Signature **Date**

CONFIDENTIAL WHEN COMPLETED

MEDICAL HISTORY VOLUNTARY (*Employee / Student completes)*

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

Yes	No	10. Have you *ever* lost vision in either eye?
☐	☐	Temporarily or permanently

Yes	No	11. Do you *currently* have any of the following vision problems?
☐	☐	Wear contact lenses
☐	☐	Wear glasses
☐	☐	Color blind
☐	☐	Any other eye or vision problem

Yes	No	12. Have you *ever had* an injury?
☐	☐	to your ears, including a broken eardrum

Yes	No	13. Do you *currently* have any of the following hearing problems?
☐	☐	Difficulty hearing
☐	☐	Wearing a hearing aid
☐	☐	Any other hearing problem

Yes	No	14. Have you *ever?*
☐	☐	A back injury

Yes	No	15. Do you *currently* have any of the following musculoskeletal problems?
☐	☐	Weakness in any of your arms, hands, legs, or feet
☐	☐	Back pain
☐	☐	Difficulty fully moving your arms and legs
☐	☐	Pain and stiffness when you lean forward or backwards at the waist
☐	☐	Difficulty fully moving your head up or down
☐	☐	Difficulty fully moving your head side to side
☐	☐	Difficulty bending at your knees
☐	☐	Difficulty squatting to the ground
☐	☐	Climbing a flight of stairs or a ladder carrying more than 25lbs
☐	☐	Any other muscle or skeletal problem that interferes with using a respirator