UCSF Student Health & Counseling
Student Academic Affairs

This questionnaire will be used in determining whether or not you have a medical condition that may affect your ability to wear a respirator. All medical information is considered confidential.

Name: _____ **Sex: M / F / Trans**

Date of Birth: _____ **Age:** _____ **Height:** __ ____ **Weight:** _____

Department or school: _____

Phone number: _____

1. Check the type of respirator you will use:

Disposable Respirator (N 95—Used for TB/SARS pt care) _____ Other Type _____

Please check appropriate box below	NO	YES
2. Have you worn a respirator before?		
If "yes," what type(s): _____		
3. Do you *currently* smoke tobacco, or have you smoked in the last month?		
4. Have you *ever had* any of the following conditions?		
a. Seizures (fits)		
b. Diabetes (sugar disease)		
c. Allergic reactions that interfere with your breathing		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling odors		
5. Have you *ever had* any of the following pulmonary or lung problems?		
a. Asbestosis		
b. Asthma/Silicosis		
c. Chronic bronchitis		
d. Emphysema		
e. Pneumonia		
f. Tuberculosis (this does NOT include PPD positive status)		
g. Pneumothorax (collapsed lung)		
h. Lung cancer		
i. Broken ribs		
j. Any chest injuries or surgeries		
k. Any other lung problem that you've been told about: _____		
6. Do you *currently* have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath		
b. Shortness of breath when walking fast on level ground or walking up a slight hill / incline		
c. Shortness of breath when walking with other people at an ordinary pace on level ground		
d. Have to stop for breath when walking at your own pace on level ground		
e. Shortness of breath when washing or dressing yourself		
f. Shortness of breath that interferes with your job		

	NO	YES
g. Coughing that produces phlegm (thick sputum)		
h. Coughing that wakes you early in the morning		
i. Coughing that occurs mostly when you are lying down		
j. Coughing up blood in the last month		
k. Wheezing		
1. Wheezing that interferes with your job		
m. Chest pain when you breathe deeply		
n. Any other symptoms that you think may be related to lung problems		
7. Have you *ever had* any of the following cardiovascular or heart problems?		
a. Heart attack		
b. Stroke		
c. Angina		
d. Heart failure		
e. Swelling in your legs or feet (not caused by walking)		
f. Heart arrhythmia (heart beating irregularly)		
g. High blood pressure		
h. Any other heart problem that you've been told about: _____		
8. Have you *ever had* any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest		
b. Pain or tightness in your chest during physical activity		
c. Pain or tightness in your chest that interferes with your job		
d. In the past two years, have you noticed your heart skipping or missing a beat		
e. Heartburn or indigestion that is not related to eating		
f. Any other symptoms that you think may be related to heat or circulation problems		
9. Do you *currently* take medication for any of the following problems?		
a. Breathing or lung problems		
b. Heart trouble		
c. Blood pressure		
d. Seizures (fits)		
If YES, please list medication:		
10. If you've used a respirator, have you ever had any of the following problems? (Skip this question if you haven't used a respirator)		
a. Eye irritation		
b. Skin allergies or rashes		
c. Anxiety		
d. General weakness or fatigue		
e. Any other problem that interferes with your use of a respirator		

Signature:_____ ***Date:*** _____/_____/_____

For Health Care Provider: ***SIGNATURE of reviewer:***_____***Date***____/____/____

Responses Reviewed, Approved for Fit Testing _____ Further Medical Evaluation Required _____

Comments: _____