UNIVERSITY OF FLORIDA

MEDICAL HISTORY QUESTIONNAIRE FOR N-95 FILTERING FACE PIECE RESPIRATORS

Occupational Medicine Program

Complete this one-time questionnaire form if you wear N-95 filtering face piece respirators for health care or animal care activities, and do not use any other type of respirator.

Name: .D.	**UF ID:**	**Date of Birth:**
Height:	**Weight:**	**Age:**

Position (Title):	**LP#:**
Supervisor:	**Department:**
Address: 653-1 West 8th Street Jax. FL 32209	**Daytime Work Number:**

Have You Worn a Respirator Before? ❑ Yes ❑ No

If Yes, describe any difficulties noted with respirator use:

Will you be wearing any other personal protective equipment? ❑ Yes ❑ No

If Yes, please describe:

Have you had or do you now have any of the following:	**Yes**	**No**
1. Lung Disease		
2. Persistent Cough		
3. Heart Trouble		
4. Shortness of Breath		
5. History of Fainting / Seizures		
6. High Blood Pressure		
7. Diabetes		
8. Feelings of Claustrophobia (Sensation of Smothering)		
9. Skin Problems / Abnormalities		
10. Heat Exhaustion / Heat Stroke		
11. Defective Vision		
12. Defective Hearing		
13. Asthma		
14. Anemia		
15. Epilepsy		
16. Back Problems		
17. Other conditions that might interferewith respirator use		
18. Are you taking any medications (prescription or over-the-counter) If Yes, LIST:		
19. Do you now or have you ever smoked? If Yes, Answer the following:		
• At what age did you start smoking?		
• How long has it been since you quit smoking?		
• How many packs per day did or do you smoke?		

Please Explain Yes Answers: (use back of form if necessary)

Employee's Signature:	**Date:**

Physician Use Only

❑ **No Restriction on N-95 Filtering Face Piece Respirator Use** ❑ **Further Evaluation Needed**

Physician's Review Signature:	**Date:**