Medical Student Precertification Evaluation for Respirator Fitness Testing

Name: _____ Graduating Class:_____ Date of Birth ___/___/_____

Questionnaire to determine fitness to be tested to wear a N95 approved respirator/mask. These masks are tight fitted to the face. Please check each item **YES** or **NO**. If you check **YES**, please provide an explanation. All questions must be answered**.** Address any questions to: UHP at JABSOMMR@UCERA.ORG

1. Have you worn an N95 or similar respirator/mask before?___No____Yes
   (If yes, what type/for what purpose?)_____
2. If yes, have you had problems wearing a respirator/mask?_____No_____Yes Explain_____
3. Do you have anxiety problems that would make wearing a respirator 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 you have any heart problems? (Angina, heart failure) ____ No ____ Yes
   If yes, are you symptomatic from heart problems, such as exertional chest pain No_____ Yes __
8. Do you have any lung/respiratory disease (chronic cough, emphysema, asthma, bronchitis)? ____ No _ Yes
   If yes, explain_____ ____ _____
9. Do you have breathlessness with activity _____No _____Yes Explain_____
10. Do you smoke? ____ No __ Yes How many packs per day? _____ For how many years? ____
11. Do you have seizures? ____ No ____ Yes If yes, are you well controlled on medication? ____
12. Do you have any other conditions that could impair your ability to wear a respirator? ____No _ _Yes
    Explain:_____
13. Do you wish to speak with someone to obtain more information about fitness for wearing a respirator mask?
    _____No _____Yes

Student Signature: _____ Date: _____

Return the complete form directly to:

University Health Partners of Hawaii
677 Ala Moana Blvd, Suite 1001
Honolulu, HI 96813
Fax (808) 447-3943 or email: JABSOMMR@UCERA.ORG