



### CHS RESPIRATOR QUESTIONNAIRE

You have previously been fit tested for a N95 respirator. University of Arizona, Campus Health Services performs annual assessments of your ability to safely wear respiratory protection. To assist us in that effort, please enter the requested information and answer all questions. Thank you for your time.

Employee/Student Name: \_\_\_\_\_ Employee/Student ID # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Department: \_\_\_\_\_ Job: \_\_\_\_\_

A change in your health can affect your ability to wear a protective mask or respirator. Such factors as, a frequent cough, recurrent wheezing, new shortness of breath, use of home oxygen, angina or chest pain all impact your ability to safely use these devices. Other relevant conditions are, newly diagnosed high blood pressure or asthma, a blood clot, rib injury, skin allergy, facial rash, claustrophobia, facial surgery, seizures, chronic fatigue, cancer therapy, use of insulin or a 20% gain or loss in your weight.

1. Have you developed any of these or other serious changes to your health, since you last completed the UArizona respirator questionnaire?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Have you been told by a nurse, doctor, supervisor or UArizona Risk Management team member that you need to be medically re-evaluated before continuing to use a respirator?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Has there been a change in your workplace conditions, work assignments, physical effort, protective clothing or anything else that seems to significantly increase the physical burden you experience in the performance of your work duties?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Would you like to be seen by an occupational health physician before being recommended for future use of an N95 or similar mask/respirator?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Your health and safety are very important to us. Please feel free to leave any additional information that you feel should be considered in the area below!	

Thank you for taking the time to complete this required annual questionnaire. Your health may depend upon safely using your respirator/N95 mask. If your health changes, your ability to safely use respiratory protection may change. Consequently, by signing below, you agree to report any significant change in your health to a Campus Health Department occupational health nurse (Immunization Department) or physician. The privacy of your health information disclosures is protected by state and federal law.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_