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

Employee ID#	**UTRGV Email address**
Phone number where you can be reached	**Best time(s) to contact you at this number**
Supervisor's name	**Supervisor's email address**

A. MEDICAL HISTORY *(Employee completes)*

Please explain all 'Yes' answers below.

Yes	No	Have you ever had any of the following conditions?
		Asthma or Reactive Airways Disease
		Chronic Bronchitis or Emphysema
		Pneumonia, Tuberculosis, or Pleurisy
		Allergic reaction that interferes with your breathing
		Allergic reaction to Bitrex (Denatonium benzoate)
		Pneumothorax or broken ribs
		High blood pressure
		Heart attack or Stroke
		Diabetes (sugar disease)
		Seizures (epilepsy; "fits")
		Cancer

Yes	No	Do you currently have any of the following symptoms?
		Shortness of breath
		Coughing up phlegm or blood
		Wheezing
		Chest pain or tightness
		Irregular heart beat or arrhythmia
		Trouble smelling odors
		Claustrophobia or anxiety when wearing a respirator

		Any other problem that may interfere 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?
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 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