

Fit Testing Questionnaire

Our affiliating hospitals are now requiring fit testing for N-95 respirators for all students and faculty. This OSHA (Occupational Safety and Health Administration, US Department of Labor) questionnaire must be completed prior to fit testing and be on file at the School of Nursing.

Download this form, complete it, and send it back to Student Services via email, fax (765-496-1800) or mail (Student Services, School of Nursing, 502 North University Street, West Lafayette, IN 47907-2069).

Part A. The following information must be provided by every student/faculty who has been selected to use any type of respirator (please print).

1. Today's date (Month/Day/Year): _____

2. Your name (Last, first): _____

3. Your age (to nearest year): _____

4. Check your gender: _____ Female _____ Male

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Check your job title, Purdue University: _____ Nursing Student _____ Faculty

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

9. The best time to phone you at this number: _____

10. The health care professional who will review this questionnaire is initially will be the Associate Head or the Program Director.

11. The type of respirator you are being fit tested for is an N-95 respirator.

12. Have you

	Yes	No
Worn a respirator before?		

If "yes," what type(s): _____

Part B. Please check either "yes" or "no"

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month:

	Yes	No
Smoked within past month		

2. Have you *ever had* any of the following conditions?

	Yes	No
Seizures		
Diabetes		
Claustrophobia		
Trouble smelling odors		

3. Have you *ever had* any of the following pulmonary or lung problems?

	Yes	No
Asbestosis		
Asthma		
Chronic bronchitis		
Emphysema		
Pneumonia		
Tuberculosis		
Silicosis		
Pneumothorax		
Lung cancer		
Broken ribs		
Any chest injuries or surgeries		
Other lung problems		

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?

	Yes	No
Shortness of breath		
Shortness of breath when walking fast on level ground or walking up a slight hill/incline		
Shortness of breath when walking with other people at an ordinary pace on level ground		
Have to stop for breath when walking at your own pace on level ground		
Shortness of breath when washing or dressing yourself		
Shortness of breath that interferes with your being a student or faculty member		
Coughing that produces phlegm (thick sputum)		
Coughing that wakes you early in the morning		
Coughing that occurs mostly when you are lying down		
Coughing up blood in the last month		
Wheezing		
Wheezing that interferes with your job		
Chest pain when you breathe deeply		
Any other symptoms that you think may be related to lung problems		

5. Have you *ever had* any of the following cardiovascular or heart problems?

	Yes	No
Heart attack		
Stroke		
Angina		
Heart failure		
Swelling in your legs or feet (not caused by walking)		
Heart arrhythmia (heart beating irregularly)		
High blood pressure		
Any other heart problem that you've been told about		

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

	Yes	No
Frequent pain or tightness in your chest		
Pain or tightness in your chest during physical activity:		
Pain or tightness in your chest that interferes with your school activities		
In the past two years, have you noticed your heart skipping or missing a beat		
Heartburn or indigestion that is not related to eating		
Any other symptoms that you think may be related to heart or circulation problems		

7. Do you *currently* take medication for any of the following problems?

	Yes	No
Breathing or lung problems		
Heart trouble		
Blood pressure		
Seizures		

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space _____ and go to question 9.)

	Yes	No
Eye irritation		
Skin allergies or rashes		
Anxiety		
General weakness or fatigue		
Any other problem that interferes with your use of a respirator		

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire:

No	
Yes	