Particulate Respirator Approval Form
UVA-WorkMed

Name (Please print) _____
Employee Date of Birth_____

	Yes	No
1. Do you smoke tobacco? If yes, how many packs per day? _____ Number of years ____		

2. Have you ever had any of the following conditions? (indicate yes or no for each)	Yes	No
a. Seizures (fits)		
b. Diabetes (sugar disease)		
c. Allergic reactions that interfere with your breathing		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling odors		

3. Have you ever had any of the following pulmonary or lung problems?	Yes	No
a. Asbestosis		
b. Chronic bronchitis more than 3 episodes in the last year		
c. Emphysema		
d. Lung cancer		
e. Silicosis		
f. Chest injuries or surgeries		
g. Asthma as an adult		
h. Pneumonia in the last month		
i. Tuberculosis (active disease)		
j. Any other lung problem that you've been told about:		

4. Do you currently have any of these symptoms of pulmonary or lung illness?	YES	NO
a. Shortness of breath		
b. Shortness of breath with light activity		
c. Shortness of breath with strenuous activity		
d. Cough that produces thick sputum or blood		
e. Cough lasting longer than 3 weeks		
f. Wheezing		
g. Wheezing that interferes with work		
h. Any other symptoms that may be related to lung problems:		

5. Have you ever had any of the following cardiovascular or heart problems?	YES	NO
a. Heart Attack		
b. Stroke		
c. Angina (chest pain)		
d. Heart failure		
e. Irregular heart beat		
f. Swelling in your legs or feet (not caused by walking)		
g. High blood pressure		
h. Any other heart problems:		

6. Have you ever had any of the following cardiovascular or heart symptoms?	YES	NO
a. Frequent pain or tightness in your chest		
b. In the past two years, have you noticed your heart skipping or missing a beat?		
c. Heartburn or indigestion that is not related to eating		
d. Any other symptoms that may be related to heart or circulation problems		

7. Do you **currently** take medication for any of the following problems?	YES	NO
a. Breathing or lung problems		
b. Heart trouble		
c. Blood pressure		
d. Seizures (fits)		

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, skip question 8 and go to question 9)	YES	NO
a. Eye irritation		
b. Skin allergies or rashes		
c. Anxiety		
d. General weakness or fatigue		
e. Any other problem that interferes with your use of a respirator		

	YES	NO
9. Would you like to talk to the health care professional who will review this survey?		
10. I have been given the Respiratory Fit Testing & Training form		

Employee Signature _____

Date: _____

----------Do not write below this line----------

Written Opinion:

____ Approved **WITHOUT** restrictions

____ Approved **WITH** restrictions

___ Do not wear if wheezing or short of breath

____ **Not approved** to wear respirator

Type N95 Mask: _____

_____ 3M 1860 ( ) Small ( ) Regular

_____ Tecnol ( ) Small ( ) Regular

_____ 3M 1870+

PAPR Required: _____

Comments:
_____
_____

Provider Signature _____

Date_____

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