Form Approved
OMB No. 0920-0109
Exp. Date xx/xx/20xx

Pre-test Questionnaire for Respirator Fit Testing
(to be completed by test administrator with exception of test participant signature)

Test participant name:_____

Emergency contact and phone number:_____

1. Do you feel well today? (circle response) Yes No*
2. Have you had a cold or flu within the last two weeks? Yes* No
3. Have you eaten or drank (other than water) within the last 30 minutes? Yes* No
4. Have you smoked during the last 30 minutes? Yes* No
5. Take a few minutes to review the activities for the test that you will be performing today. Is there any reason why performing the tasks described may be unsafe? Yes* No
6. Have you experienced any of the following conditions since your last visit to our laboratory? Yes* No

- Shortness of breath
- Wheezing
- Pregnancy
- Pain or tightness in your chest
- Irregular heartbeat
- High or low blood pressure
- Fainting or dizzy spells
- Any other lung or heart problems
- Unusual, severe headaches
- Extremity numbness or tingling
- Pain or discomfort in your legs when walking
- A seizure

Test participant signature:_____ Date:_____

Test administrator's name:_____

*(*These answers indicate that participant should not test today. Mark "Do not test" below. If "Yes" marked for question #6, mark "Consult with health care professional".)*

□ Test □ Do not test □ Consult with health care professional**

*(**If consulting with health care professional/provider, "test" or "do not test" should be marked by health care professional. Continue on next page.)*

Health care professional/provider name/date:_____

Health care professional/provider signature: _____