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: