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:____________________________________

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSD Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0109).

*(*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: ____________________________