

UWO Respirator User's Health Conditions

Check Yes or No boxes only. **Do not specify. Condition** (complete prior to respirator fitting)

- a) Some conditions can seriously affect your ability to safely use a respirator. Do you or do you experience any of the following, or another condition which may affect respirator use? Yes No

Shortness of breath	Breathing difficulties	Chronic bronchitis	Emphysema
Lung disease	Chest pain on exertion	Heart problems	Allergies
Hypertension	Cardiovascular disease	Thyroid problems	Diabetes
Neuromuscular disease	Fainting spells	Dizziness/nausea	Seizures
Temperature susceptibility	Claustrophobia/fear of heights	Hearing impairment	Dentures
Panic attacks	Colour blindness	Asthma	Pacemaker
Vision impairment	Reduced sense of smell	Reduced sense of taste	Back/neck problems
Facial features/skin conditions			

- b) Do you take prescription medication(s) to control a condition which you believe may affect respirator use? Yes No

- c) Do you have any other medical condition(s) which you believe may affect respirator use? Yes No

- d) Have you had previous difficulty using a respirator? Yes No

- e) Do you have any future concerns about your ability to use a respirator safely? Yes No

A yes answer to "a" "b" "c" "d" or "e" requires a further assessment by a health care professional and the bottom section of the form completed, prior to respirator use **Note medical information is Not to be offered on this form.**

Name of Respirator User: _____

Signature of Respirator User: _____

Date: _____

To be completed by Workplace Health

Employee is fit for respirator use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Signature of Workplace Health Representative

Date