



Student ID#: _____

Medical Questionnaire for Personal Protective Equipment

Name _____	Social Security No. _____		
Date _____	Age _____	Height _____	Weight _____
Have you ever worn a respirator before? _____ Yes _____ No			
If YES, describe any apparent difficulties noted with respirator use: _____			

Have you had or do you now have any of the following:	YES*	NO
1. Lung disease	<input type="checkbox"/>	<input type="checkbox"/>
2. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
3. History of fainting or seizures	<input type="checkbox"/>	<input type="checkbox"/>
4. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
6. Fear of tight or enclosed places	<input type="checkbox"/>	<input type="checkbox"/>
7. Sensation of smothering	<input type="checkbox"/>	<input type="checkbox"/>
8. Heat exhaustion or heat stroke	<input type="checkbox"/>	<input type="checkbox"/>
9. Ruptured ear drum	<input type="checkbox"/>	<input type="checkbox"/>
10. Defective vision	<input type="checkbox"/>	<input type="checkbox"/>
11. Defective hearing	<input type="checkbox"/>	<input type="checkbox"/>
12. Contact lenses or glasses	<input type="checkbox"/>	<input type="checkbox"/>
13. Other conditions that might interfere with respirator use or result in limited work ability	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>

* Please explain YES answers

Applicants Signature

Date