Toma Health Solutions
Tel: 647-847-1702
Email: contact@tomahs.ca
www.tomahs.ca

INSTRUCTIONS FOR FIT TEST APPOINTMENT

Please read all instructions carefully before completing the questionnaire

- Some symptoms/conditions can affect your ability to be safely tested and use a respiratory mask

- If you select "Yes" to **ANY** questions on page 2, please contact us. You may need to see your family doctor to review and discuss any concerns.

- Please bring your puffers or necessary/emergency medication with you on the day of testing.

- On the day of your appointment, do not **Eat, Smoke, Drink** or **Chew Gum 20 minutes** prior to your fit test.

- Tests cannot be performed on individuals with **FACIAL HAIR.** If you cannot shave because of religious or cultural reasons, please discuss it with the technician at least 24 hours prior to your appointment

- Please ensure you are available at your booked appointment time

- Failure to meet any of the above may result in a refusal to be tested and require rebooking

By signing at the bottom of the questionnaire, the individual agrees to the following:

- The individual fully understands the rules and procedures of the Mask Fit Testing process
- That all information provided is correct
- Any issues or concerns will be discussed with the technician prior to testing
- Any non-compliance will result in a refusal to be tested

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N95 RESPIRATOR HEALTH QUESTIONNAIRE

(This form is confidential)

Name:	**DOB:**
Home Address:	**Telephone:**

1. Have you ever worn a respirator and had difficulties using the respirator? ☐ Yes ☐ No
   - Eye Irritation ☐ Yes ☐ No
   - Skin Irritation or rash ☐ Yes ☐ No
   - If yes, please describe _____

2. Have you ever had any of the following respiratory conditions?
   Asthma/COPD: ☐ Yes ☐ No Pneumonia: ☐ Yes ☐ No
   Chronic Bronchitis: ☐ Yes ☐ No Emphysema: ☐ Yes ☐ No
   (If you take medication for asthma, please bring it with you to the fit testing)

3. Do you have any other lung or breathing problems? ☐ Yes ☐ No
   - If yes, please describe: _____

4. Have you ever had any of the following conditions:
   Epilepsy/Seizure Disorder: ☐ Yes ☐ No Diabetes: ☐ Yes ☐ No
   History of fainting: ☐ Yes ☐ No Heart Problems ☐ Yes ☐ No
   High Blood Pressure: ☐ Yes ☐ No Claustrophobia: ☐ Yes ☐ No

   - Besides the medical conditions listed above, are you currently taking a prescription and/or over the counter medication with full symptoms that may interfere with wearing a mask, such as: ☐ Yes ☐ No
     - Shortness of breath, breathing difficulties, chest pain, light headedness

5. Have you ever had any allergic reactions that interfere with your breathing? ☐ Yes ☐ No

6. Do you have Latex sensity/allergy or any other allergies? ☐ Yes ☐ No

Client Signature: _____ **Witness:** _____ **Date:** _____