Your Hospital's Logo Here

INITIAL POST-ASBESTOS EXPOSURE MEDICAL QUESTIONNAIRE

Please complete this confidential questionnaire by placing a check mark √ in the appropriate spaces or by printing other information when required . (Use black or blue ink).

IDENTIFICATION

1. NAME: _____

2. SOCIAL SECURITY NUMBER #: _____

3. CLOCK NUMBER: _____

4. PRESENT OCCUPATION: _____

5. PLANT: _____

6. ADDRESS: _____

7. _____
(Zip Code)

8. TELEPHONE NUMBER: _____

9. INTERVIEWER: _____

10. DATE: _____

11. DATE OF BIRTH: _____
Month Day Year

12. PLACE OF BIRTH: _____

13. SEX: ☐ Male ☐ Female

14. WHAT IS YOUR MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Seperated / Divorced

15. RACE: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Indian ☐ Other _____

16. WHAT IS THE HIGHEST GRADE COMPLETED IN SCHOOL: _____
(For example 12 years is completion of high school)

OCCUPATIONAL HISTORY

17. **A.** Have you ever worked full time (30 hours per week or more) for 6 months or more ? ☐ YES ☐ NO
IF YES TO 17A:

B. Have you ever worked for a year or more in any dusty job ? ☐ YES ☐ NO ☐ DOES NOT APPLY

Specific Job / Industry _____ Total Years Worked _____

Was dust exposure: ☐ Mild ☐ Moderate ☐ Severe

C. Have you ever been exposed to gas or chemical fumes in your work ? ☐ YES ☐ NO

Specific Job / Industry _____ Total Years Worked _____

Was dust exposure: ☐ Mild ☐ Moderate ☐ Severe

D. What has been your usual occupation or job - - the one you have worked at the longest ?

1. Job occupation _____

2. Number of years employed in this occupation _____

3. Position / job title _____

4. Business, field or industry _____
(Record on lines the years in which you have worked in any of these industries, e.g. 1960 - 1969)

OCCUPATIONAL HISTORY (Continued)

HAVE YOU EVER WORKED:

17. E. In a mine ? ☐YES ☐NO

F. In a foundry ? ☐YES ☐NO

G. In a pottery ? ☐YES ☐NO

H. In a cotton, flax or hemp mill ? ☐YES ☐NO

I. With asbestos ? ☐YES ☐NO

PAST MEDICAL HISTORY

18. A. Do you consider yourself to be in good health ? ☐YES ☐NO

If "NO" state reason _____

B. Do you have any defect of vision ? ☐YES ☐NO

If "YES" state nature of defect _____

C. Do you have any hearing defect ? ☐YES ☐NO

If "YES" state nature of defect _____

D. Are you suffering from or have you suffered from:

a. Epilepsy (or fits, seizures, convulsions) ? ☐YES ☐NO

b. Rheumatic fever ? ☐YES ☐NO

c. Kidney disease ? ☐YES ☐NO

d. Bladder disease ? ☐YES ☐NO

e. Diabetes ? ☐YES ☐NO

f. Jaundice ? ☐YES ☐NO

CHEST COLDS AND CHEST ILLNESSES

19. A. If you get a cold, does it "usually" go to your chest ? (Usually means more than 1/2 the time) ☐YES ☐NO ☐ DON'T GET COLDS

20. A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed ? ☐YES ☐NO

IF YES TO 20A:

B. Did you produce phlegm with any of these chest illnesses ? ☐YES ☐NO ☐ DOES NOT APPLY

C. In the last 3 years, how many such illnesses with (increased) phelgm did you have which lasted a week or more ? _____ NUMBER OF ILLNESSES ☐ NO SUCH ILLNESSES

21. Did you have any lung trouble before the age of 16 ? ☐YES ☐NO

22. Have you ever had any of the following

1. A. Attacks of bronchitis ☐YES ☐NO

IF YES TO 1A:

B. Was it confirmed by a doctor ? ☐YES ☐NO ☐ DOES NOT APPLY

C. At what age was your first attack ? _____ AGE IN YEARS ☐ NO SUCH ILLNESSES

2. A. Pneumonia (include bronchopneumonia) ☐YES ☐NO

IF YES TO 2A:

B. Was it confirmed by a doctor ? ☐YES ☐NO ☐ DOES NOT APPLY

C. At what age was your first attack ? _____ AGE IN YEARS ☐ NO SUCH ILLNESSES

3. A. Hay Fever ? ☐YES ☐NO

IF YES TO 3A:

CHEST COLDS AND CHEST ILLNESSES (Continued)

B. Was it confirmed by a doctor ? ☐YES ☐NO ☐ DOES NOT APPLY

C. At what age did it start ? _____ AGE IN YEARS ☐ DOES NOT APPLY

23. A. Have you ever had chronic bronchitis ? ☐YES ☐NO

IF YES TO 23A:

B. Do you still have it ? ☐YES ☐NO ☐ DOES NOT APPLY

C. Was it confirmed by a doctor ? ☐YES ☐NO ☐ NO SUCH APPLY

D. At what age did it start ? _____ AGE IN YEARS ☐ DOES NOT APPLY

24. A. Have you ever had emphysema ? ☐YES ☐NO

IF YES TO 24A:

B. Do you still have it ? ☐YES ☐NO ☐ DOES NOT APPLY

C. Was it confirmed by a doctor ? ☐YES ☐NO ☐ NO SUCH APPLY

D. At what age did it start ? _____ AGE IN YEARS ☐ DOES NOT APPLY

25. A. Have you ever had asthma ? ☐YES ☐NO

IF YES TO 25A:

B. Do you still have it ? ☐YES ☐NO ☐ DOES NOT APPLY

C. Was it confirmed by a doctor ? ☐YES ☐NO ☐ NO SUCH APPLY

D. At what age did it start ? _____ AGE IN YEARS ☐ DOES NOT APPLY

E. If you no longer have it, at what age did it stop ? _____ AGE IN YEARS ☐ DOES NOT APPLY

26. Have you ever had:

A. Any other chest illnesses ? ☐YES ☐NO

If yes, please specify _____

B. Any chest operations ? ☐YES ☐NO

If yes, please specify _____

C. Any chest injuries ? ☐YES ☐NO

If yes, please specify _____

27. A. Has a doctor ever told you that you had heart trouble ? ☐YES ☐NO

IF YES TO 27A:

B. Have you ever had treatment for heart trouble in the past 10 years ? ☐YES ☐NO ☐ DOES NOT APPLY

28. A. Has a doctor ever told you that you had high blood pressure ? ☐YES ☐NO

IF YES TO 28A:

B. Have you had any treatment for high blood pressure (hypertension) in the past 10 years ? ☐YES ☐NO ☐ DOES NOT APPLY

29. When did you have your chest X-Rayed ? _____ (YEAR)

30. Where did you have your chest X-Rayed (if known) ?

_____

What as the outcome ? _____

FAMILY HISTORY

31. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

	FATHER			MOTHER		
	YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
A. Chronic Bronchitis ?	☐	☐	☐	☐	☐	☐
B. Emphysema ?	☐	☐	☐	☐	☐	☐
C. Asthma ?	☐	☐	☐	☐	☐	☐
D. Lung Cancer ?	☐	☐	☐	☐	☐	☐
E. Other chest conditions ?	☐	☐	☐	☐	☐	☐
F. Is parent currently alive ?	☐	☐	☐	☐	☐	☐
G. Parent's age if living ?	----------		☐	----------		☐
Parent's age at death ?	----------		☐	----------		☐

H. _____ **FATHER'S** CAUSE OF DEATH (if applicable)

_____ **MOTHER'S** CAUSE OF DEATH (if applicable)

COUGH

32. A. Do you usually have a cough ? ☐YES ☐NO
(Count a cough with first smoke or on first going out doors. Exclude clearing of throat.)
IF NO, SKIP TO QUESTION 32C:

B. Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week ? ☐YES ☐NO

C. Do you usually cough at all on getting up or first thing in the morning ? ☐YES ☐NO

D. Do you usually cough at all during the rest of the day or at night ? ☐YES ☐NO
IF YES TO ANY OF ABOVE (32A, B, C, OR D), ANSWER THE FOLLOWING:
IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO 33A.

E. Do you usually cough like this on most days for 3 consecutive months or more per year ? ☐YES ☐NO ☐ DOES NOT APPLY

F. For how many years have you had the cough ? _____ NUMBER OF YEARS ☐ DOES NOT APPLY

EPISODES OF COUGH AND PHLEGM

33. A. Do you usually bring up phlegm from your chest ? ☐YES ☐NO
(Count phlegm with the first smoke or on first going outdoors. Exclude phlegm from the nose. Count swallowed phlegm.)
IF NO, SKIP TO QUESTION 33C:

B. Do you usually bring up phlegm like this as much as twice a day 4 or more days per week ? ☐YES ☐NO

C. Do you usually bring up phlegm at all on getting up or first thing in the morning ? ☐YES ☐NO

D. Do you usually bring up phlegm at all during the rest of the day or at night ? ☐YES ☐NO
IF YES TO ANY OF ABOVE (33A, B, C, OR D), ANSWER THE FOLLOWING:
IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO 34A.

E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year ? ☐YES ☐NO ☐ DOES NOT APPLY

F. For how many years have you had trouble with phlegm ? _____ NUMBER OF YEARS ☐ DOES NOT APPLY

34. A. Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more per year ? ☐YES ☐NO
* (For persons who usually have cough and / or phlegm)
IF YES TO 34A:

B. For how long have you had at least 1 such episode per year ? _____ NUMBER OF YEARS ☐ DOES NOT APPLY

WHEEZING

35. A. Does your chest ever sound wheezy or whistling:

1. When you have a cold ? ☐YES ☐NO

WHEEZING (Continued)

35. **2.** Occasionally apart from colds ? ☐ YES ☐ NO

3. Most days or nights ? ☐ YES ☐ NO
IF YES TO 1, 2, OR 3 IN 35A:

B. For how many years has this been present ? _____ NUMBER OF YEARS ☐ DOES NOT APPLY

36. **A.** Have you ever had an attack of wheezing that has made you feel short of breath ? ☐ YES ☐ NO
IF YES TO 36A:

B. How old were you when you had your first such attack ? _____ YEARS OLD ☐ DOES NOT APPLY

C. Have you had 2 or more such episodes ? ☐ YES ☐ NO ☐ DOES NOT APPLY

D. Have you ever required medicine or treatment for the(se) attack(s) ? ☐ YES ☐ NO ☐ DOES NOT APPLY

BREATHLESSNESS

37. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 39A.

Nature of Condition _____

_____

38. **A.** Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill ? ☐ YES ☐ NO
IF YES TO 38A:

B. Do you have to walk slower than people of your age on the level due to breathlessness ? ☐ YES ☐ NO ☐ DOES NOT APPLY

C. Do you ever have to stop for breath when walking at your own pace on the level ? ☐ YES ☐ NO ☐ DOES NOT APPLY

D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level ? ☐ YES ☐ NO ☐ DOES NOT APPLY

E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs ? ☐ YES ☐ NO ☐ DOES NOT APPLY

TOBACCO SMOKING

39. **A.** Have you ever smoked cigarettes ? ☐ YES ☐ NO
(NO means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime, or less than 1 cigarette a day for 1 year).
IF YES TO 39A:

B. Do you now smoke cigarettes (as of one month ago) ? ☐ YES ☐ NO ☐ DOES NOT APPLY
minutes) on the level ?

C. How old were you when you first started regular cigarette smoking ? _____ AGE IN YEARS ☐ DOES NOT APPLY

D. If you have stopped smoking cigarettes completely, how old were you when you stopped ? _____ AGE IN YEARS ☐ STILL SMOKE ☐ DOES NOT APPLY

E. How many cigarettes do you smoke per day now ? _____ CIGARETTES PER DAY ☐ DOES NOT APPLY

F. On the average of the entire time you smoked, how many cigarettes did you smoke per day ? _____ CIGARETTES PER DAY ☐ DOES NOT APPLY

G. Do you or did you inhale the cigarette smoke ? ☐ DOES NOT APPLY ☐ NOT AT ALL
☐ SLIGHTLY ☐ MODERATELY ☐ DEEPLY

40. **A.** Have you ever smoked a pipe regularly ? ☐ YES ☐ NO
(YES means more than 12 oz. of tobacco in a lifetime).
IF YES TO 40A: FOR PERSONS WHO HAVE EVER SMOKED A PIPE

B. **1.** How old were you when you first started to smoke a pipe regularly ? _____ AGE IN YEARS ☐ DOES NOT APPLY

TOBACCO SMOKING (Continued)

40. B. 2. If you have stopped smoking a pipe completely, how old were you when you stopped ?
_____ AGE IN YEARS ☐ STILL SMOKE ☐ DOES NOT APPLY

C. On the average of the entire time you smoked a pipe, how much pipe tobacco did you smoke per week ?
(A standard pouch of tobacco contains 1.5 oz.)
_____ OUNCES PER WEEK ☐ DOES NOT APPLY

D. How much pipe tobacco are you smoking now ?
_____ OUNCES PER WEEK ☐ DOES NOT APPLY

E. Do you or did you inhale the pipe smoke ?
☐ DOES NOT APPLY ☐ NOT AT ALL ☐ SLIGHTLY ☐ MODERATELY ☐ DEEPLY

41. A. Have you ever smoked cigars regularly ?
(YES means more than 1 cigar a week for a year).
☐ YES ☐ NO

IF YES TO 40A: FOR PERSONS WHO HAVE EVER SMOKED CIGARS

B. 1. How old were you when you first started to smoke cigars regularly ?
_____ AGE IN YEARS ☐ DOES NOT APPLY

2. If you have stopped smoking cigars completely, how old were you when you stopped ?
_____ AGE IN YEARS ☐ STILL SMOKE ☐ DOES NOT APPLY

C. On the average of the entire time you smoked cigars, how many cigars did you smoke per week ?
_____ CIGARS PER WEEK ☐ DOES NOT APPLY

D. How many cigars are you smoking now ?
_____ OUNCES PER WEEK ☐ DOES NOT APPLY

E. Do you or did you inhale the cigar smoke ?
☐ DOES NOT APPLY ☐ NOT AT ALL ☐ SLIGHTLY ☐ MODERATELY ☐ DEEPLY

EMPLOYEE SIGNATURE:	DATE:

DRUG ALLERGY:	GENERAL HEALTH:	WEIGHT:	RESP:	BP:	PULSE:

	Normal	Abnormal	Not Done	Findings
Heart	☐	☐	☐	
Lungs	☐	☐	☐	
Extremities	☐	☐	☐	
Vascular-Pulses	☐	☐	☐	
Gastrointestinal	☐	☐	☐	

PFT	CHEST X-RAY
☐ Done ☐ Not Done	☐ Done ☐ Not Done

FREQUENCY OF CHEST X-RAY

YEARS SINCE EXPOSURE	15 TO 35 YEARS OLD	35+ TO 45 YEARS OLD	45+ YEARS OLD
0 to 10 years	Every 5 years	Every 5 years	Every 5 years
10+ years	Every 5 years	Every 2 years	Every 1 year

Assessment / Referral Plan / Recommendations **COMMENTS / REFERRAL**

(1) _____ _____

(2) _____ _____

PROVIDER SIGNATURE:	DATE: