Your Hospital's Logo Here

PERIODIC
MEDICAL QUESTIONNAIRE

Please complete this confidential questionnaire by placing a check mark in the appropriate 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: _____

8. TELEPHONE NUMBER: _____

9. INTERVIEWER: _____ **10.** DATE: _____

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

OCCUPATIONAL HISTORY

12. A. In the past year, did you work full time (30 hours per week or more) for 6 months or more ? ☐ YES ☐ NO

IF YES TO 12A:

B. In the past year, did you work in a dusty job ? ☐ YES ☐ NO ☐ DOES NOT APPLY

C. Was dust exposure: ☐ Mild ☐ Moderate ☐ Severe

D. In the past year, were you exposed to gas or chemical fumes at work ? ☐ YES ☐ NO

E. Was exposure: ☐ Mild ☐ Moderate ☐ Severe

F. In the past year, what was your:

1. Job occupation _____

2. Position / job title _____

RECENT MEDICAL HISTORY

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

If "NO" state reason _____

B. In the past year, have you developed:

Epilepsy ?	☐ YES	☐ NO	Diabetes ?	☐ YES	☐ NO
Rheumatic fever ?	☐ YES	☐ NO	Jaundice ?	☐ YES	☐ NO
Kidney disease ?	☐ YES	☐ NO	Cancer ?	☐ YES	☐ NO
Bladder disease ?	☐ YES	☐ NO			

CHEST COLDS AND CHEST ILLNESSES

14. 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

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

IF YES TO 15A:

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

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

RESPIRATORY SYSTEM

16. A. In the past year, have you had:

			FURTHER COMMENT on POSITIVE ANSWERS
Asthma ?	☐ YES	☐ NO	
Bronchitis ?	☐ YES	☐ NO	
Hay Fever ?	☐ YES	☐ NO	
Other Allergies ?	☐ YES	☐ NO	
Pneumonia ?	☐ YES	☐ NO	
Tuberculosis ?	☐ YES	☐ NO	
Chest Surgery ?	☐ YES	☐ NO	
Other Lung Problems ?	☐ YES	☐ NO	

B. Do you have:

Frequent colds ?	☐ YES	☐ NO	
Chronic cough ?	☐ YES	☐ NO	
Shortness of breath when walking or climbing one flight of stairs	☐ YES	☐ NO	

C. Do you:

Wheeze ?	☐ YES	☐ NO	
Cough up phlegm ?	☐ YES	☐ NO	
Smoke cigarettes ?	☐ YES	☐ NO	

1. Packs per day _____
2. How many years _____

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: