PERIODIC MEDICAL QUESTIONNAIRE
ASBESTOS

1. NAME _____ History Number _____

2. SOCIAL SECURITY # ___ ___ ___ ___ ___ ___ ___ ___ ___

3. CLOCK NUMBER ___ ___ ___ ___ ___ ___ ___

4. PRESENT OCCUPATION_____

5. PLANT _____

6. ADDRESS _____

7. _____
(Zip Code)

8. TELEPHONE NUMBER _____

9. INTERVIEWER _____

10. DATE _____ ___ ___ ___ ___ ___ ___

11. What is your marital status? 1. Single ___ 4. Separated/.
2. Married ___ Divorced ___
3. Widowed ___

12. OCCUPATIONAL HISTORY

12A. In the past year, did you work full time (30 hours per week or more) for 6 months or more? 1. Yes ___ 2. No ___

IF YES TO 12A:

12B. In the past year, did you work in a dusty job? 1. Yes ___ 2. No ___ 3. Does not Apply ___

12C. Was dust exposure:
1. Mild ___ 2. Moderate ___ 3. Severe ___

12D. In the past year, were you exposed to gas or chemical fumes in your work? 1. Yes ___ 2. No ___

12E. Was exposure: 1. Mild ___ 2. Moderate ___ 3. Severe ___

12F. In the past year, what was your:
1. Job/occupation? _____
2. Position/job title? _____

13. RECENT MEDICAL HISTORY

13A. Do you consider yourself to be in good health? Yes ___ No ___

If NO, state reason _____

13B. In the past year, have you developed:

	Yes	No
Epilepsy?	___	___
Rheumatic fever?	___	___
Kidney disease?	___	___
Bladder disease?	___	___
Diabetes?	___	___
Jaundice?	___	___
Cancer?	___	___

14. CHEST COLDS AND CHEST ILLNESSES

14A. If you get a cold, does it "usually" go to your chest? (usually means more than 1/2 the time)

1. Yes ___ 2. No ___
3. Don't get colds ___

15A. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? 1. Yes ___ 2. No ___ 3. Does Not Apply ___

IF YES TO 15A:

15B. Did you produce phlegm with any of these chest illnesses? 1. Yes ___ 2. No ___ 3. Does Not Apply ___

15C. In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more? Number of illnesses ___ No such illnesses ___

16. RESPIRATORY SYSTEM

In the past year have you had:

	Yes or No	Further Comment on Positive Answers
Asthma	_____	
Bronchitis	_____	
Hay Fever	_____	
Other Allergies	_____	

	Yes or No	Further Comment on Positive Answers
Pneumonia	_____	
Tuberculosis	_____	
Chest Surgery	_____	
Other Lung Problems	_____	
Heart Disease	_____	

Do you have:

	Yes or No	Further Comment on Positive Answers
Frequent colds	_____	
Chronic cough	_____	
Shortness of breath when walking or climbing one flight or stairs	_____	

Do you:

Wheeze	_____	
Cough up phlegm	_____	
Smoke cigarettes	_____	Packs per day ____ How many years ___

Date _____ Signature _____