

MINNESOTA OCCUPATIONAL HEALTH

1661 St Anthony Avenue, St Paul, MN 55104
Telephone (651) 842-5300 Fax (651) 646-0205

INITIAL HAZMAT/ASBESTOS MEDICAL QUESTIONNAIRE

Date: ____ / ____ / ____

NAME: _____ SS#: _____ - _____ - _____

COMPANY: _____

1. OCCUPATIONAL HISTORY

A. Have you ever worked full time (30 hours per week or more) for 6 months or more? 1. Yes ____ 2. No ____

IF YES, TO 1B:

B. Have you ever worked for a year or more in any dusty job? 1. Yes ____ 2. No ____
3. Does not apply ____

Specific job/industry: _____ Total years worked _____

Was dust exposure: 1. Mild ____ 2. Moderate ____ 3. Severe ____

C. Have you ever been exposed to gas or chemical fumes in your work? 1. Yes ____ 2. No ____

Specific job/industry _____ Total years worked _____

Was the exposure: 1. Mild ____ 2. Moderate ____ 3. 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)

Have you ever worked:

E. In a mine? 1. Yes ____ 2. No ____

- F. In a quarry? 1. Yes _____ 2. No _____
- G. In a foundry? 1. Yes _____ 2. No _____
- H. In a pottery? 1. Yes _____ 2. No _____
- I. In a cotton, flax or hemp mill? 1. Yes _____ 2. No _____
- J. With asbestos? 1. Yes _____ 2. No _____

1. PAST MEDICAL HISTORY

- A. Do you consider yourself to be in good health? 1. Yes _____ 2. No _____
 If "NO", state reason _____
- B. Have you any defect of vision? 1. Yes _____ 2. No _____
 If "YES", state nature of defect _____
- C. Have you any hearing defect? 1. Yes _____ 2. No _____
 If "YES", state nature of defect _____
- D. Are you suffering from or have you ever suffered from:
- 1. Epilepsy (or fits, seizures, convulsions)? 1. Yes _____ 2. No _____
 - 2. Rheumatoid fever? 1. Yes _____ 2. No _____
 - 3. Kidney disease? 1. Yes _____ 2. No _____
 - 4. Bladder disease? 1. Yes _____ 2. No _____
 - 5. Diabetes? 1. Yes _____ 2. No _____
 - 6. Jaundice? 1. Yes _____ 2. No _____

CHEST COLDS AND CHEST ILLNESSES

- A. 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 _____

- B. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors, at home, or in bed? 1. Yes_____ 2. No_____
- If "YES", to 3C:
- C. Did you produce phlegm with any of these chest illnesses? 1. Yes_____ 2. No_____ 3. Does not apply_____
- D. In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more? Number of illnesses_____
- E. Did you have any lung trouble before the age of 16? 1. Yes_____ 2. No_____
- F. Have you ever had any of the following:
- 1A. Attacks of bronchitis? 1. Yes_____ 2. No_____
- If "YES", to 1B:
- 1B. Was it confirmed by a doctor? 1. Yes_____ 2. No_____
- 1C. At what age was your first attack? 1. Yes_____ 2. No_____
- 2A. Pneumonia (include bronchopneumonia)? 1. Yes_____ 2. No_____
- If "YES", to 2B:
- 2B. Was it confirmed by a doctor? 1. Yes_____ 2. No_____ 3. Does not apply_____
- 2C. At what age did you first have it? Age in years_____ Does not apply_____
- 3A. Hay fever? 1. Yes_____ 2. No_____
- If "YES", to 3B:
- 3B. Was it confirmed by a doctor? 1. Yes_____ 2. No_____ 3. Does not apply_____
- 3C. At what age did it start? Age in years_____ Does not apply_____
- G. Have you ever had chronic bronchitis? 1. Yes_____ 2. No_____
- If "YES", to G1:
1. Do you still have it? 1. Yes_____ 2. No_____ 3. Does not apply_____

2. Was it confirmed by a doctor? 1. Yes_____ 2. No_____ 3. Does not apply_____

3. At what age did it start? Age in years_____ Does not apply_____

H. Have you ever had emphysema? 1. Yes_____ 2. No_____

If "YES", to H1:

1. Do you still have it? 1. Yes_____ 2. No_____ 3. Does not apply_____

2. Was it confirmed by a doctor? 1. Yes_____ 2. No_____ 3. Does not apply_____

3. At what age did it start? Age in years_____ 3. Does not apply_____

I. Have you ever had asthma?

If "YES", to I1:

1. Do you still have it? 1. Yes_____ 2. No_____ 3. Does not apply_____

2. Was it confirmed by a doctor? 1. Yes_____ 2. No_____ 3. Does not apply_____

3. At what age did it start? Age in years_____ 3. Does not apply_____

4. If you no longer have it, at what age did it stop Age in years_____ Does not apply_____

J. Have you ever had:

1. Any other chest illness? 1. Yes_____ 2. No_____

If "YES" please specify_____

2. Any chest operations? 1. Yes_____ 2. No_____

If "YES" please specify_____

3. Any chest injuries? 1. Yes_____ 2. No_____

If "YES" please specify_____

K. Has a doctor ever told you that you had heart trouble? 1. Yes_____ 2. No_____

If "YES", to K1:

1. Have you ever had treatment for heart trouble in the past 10 years? 1. Yes_____ 2. No_____

L. Has a doctor ever told you that you had high blood pressure? 1. Yes_____ 2. No_____

If "YES", to L1:

1. Have you had any treatment for high blood pressure (hypertension) in the past 10 years? 1. Yes_____ 2. No_____

M. When did you last have your chest x-rayed? (Year)_____

N. Where did you last have your chest x-rayed? (If known)_____

What was the outcome? (normal, abnormal)_____

2FAMILY HISTORY

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

	FATHER			MOTHER		
	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>
1. Chronic Bronchitis?	_____	_____	_____	_____	_____	_____
2. Emphysema?	_____	_____	_____	_____	_____	_____
3. Asthma?	_____	_____	_____	_____	_____	_____
4. Lung Cancer?	_____	_____	_____	_____	_____	_____
5. Other Chest Conditions?	_____	_____	_____	_____	_____	_____
6. Is parent alive?	_____	_____	_____	_____	_____	_____
7. Please specify:	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

8. Please specify cause of death_____

3. COUGH

- A. Do you usually have a cough? 1. Yes _____ 2. No _____
(Count a cough with first smoke or on first going out of doors, exclude clearing of throat.) If “NO”, skip to question 5C.)
- B. Do you usually cough as much as 4 to 6 times a day, 4 or more days out of the week? 1. Yes _____ 2. No _____
- C. Do you usually cough at all on getting up or first thing in the morning? 1. Yes _____ 2. No _____
- D. Do you usually cough at all during the rest of the day or night? 1. Yes _____ 2. No _____

IF YES TO ANY OF THE ABOVE (A, B, C, OR D), ANSWER THE FOLLOWING. IF “NO” TO ALL, SKIP TO 6.

- E. Do you usually cough like this on most days for 3 consecutive months or more during the year? 1. Yes _____ 2. No _____
- F. For how many years have you had the cough? Number of years _____
3. Does not apply
- G. Do you usually bring phlegm like this as much as twice a day, 4 or more days out of the week? 1. Yes _____ 2. No _____
- H. Do you usually bring up phlegm at all on getting up or first thing in the morning? 1. Yes _____ 2. No _____
- I. Do you usually bring up phlegm at all during the rest of the day or night? 1. Yes _____ 2. No _____

IF “YES” TO ANY OF THE ABOVE (G, H, I), ANSWER THE FOLLOWING. IF “NO” TO ALL, SKIP TO 6.

- J. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year? 1. Yes _____ 2. No _____
3. Does not apply
- K. For how many years have you had trouble with phlegm? Number of years _____
Does not apply _____

4. EPISODES OF COUGH AND PHLEGM

- A. Have you had periods or episodes of (increased) cough and phlegm lasting for 3 weeks or more each year? 1. Yes _____ 2. No _____
(For persons who usually have cough and/or phlegm.)

If "YES", to B:

B. For how long have you had at least 1 such episode per year?

Number of years _____

Does not apply _____

5. WHEEZING

A. Does your chest ever sound wheezy or whistling?

1. Yes _____ 2. No _____

1. When you have a cold?

1. Yes _____ 2. No _____

2. Occasionally apart from colds?

1. Yes _____ 2. No _____

3. Most days or nights?

1. Yes _____ 2. No _____

B. Have you ever had an attack of wheezing that has made you feel short of breath?

1. Yes _____ 2. No _____

If "YES", to B1:

1. How old were you when you had your first such attack?

Age in years _____

2. Have you had 2 or more such episodes?

1. Yes _____ 2. No _____

3. Does not apply _____

3. Have you ever required medicine or treatment for the attacks?

1. Yes _____ 2. No _____

3. Does not apply _____

6. BREATHLESSNESS

A. If disabled from walking by any condition other than heart or lung disease, please describe.

Nature of condition: _____

B. Are you troubled by shortness of breath when hurrying or walking up a slight hill?

1. Yes _____ 2. No _____

3. Does not apply _____

If "YES", to B1:

1. Do you have to walk slower than people of your age on the level because of breathlessness?

1. Yes _____ 2. No _____

3. Does not apply _____

2. Do you ever have to stop for breath when walking at your own pace on the level?

1. Yes _____ 2. No _____

3. Does not apply _____

3. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?

1. Yes _____ 2. No _____

3. Does not apply _____

4. Are you too breathless to leave the house or breathless on dressing or climbing on flight of stairs?

1. Yes _____ 2. No _____
3. Does not apply _____

7. TOBACCO SMOKING

A. Have you ever smoked cigarettes? (“Yes” 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.)

1. Yes _____ 2. No _____

B. Do you now smoke cigarettes (as of one month ago)?

1. Yes _____ 2. No _____

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 _____

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 have smoked, how many cigarettes have you smoked per day?

Cigarettes per day _____
Does not apply _____

G. Do you now or did you ever inhale the cigarette smoke?

1. Does not apply _____
2. Not at all _____
3. Slightly _____
4. Moderately _____
5. Deeply _____

H. Have you ever smoked a pipe regularly?
 (“YES” means more than 12 oz. of tobacco in a lifetime.)

1. Yes _____ 2. No _____

IF “YES”, TO H1: (For persons who have ever smoked a pipe.)

1. Yes _____ 2. No _____

1. How old were you when you started to smoke a pipe regularly?

Age _____

2. If you have stopped smoking a pipe completely, how old were you when you stopped?

Age stopped _____
Still smoking _____
Does not apply _____

3. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoker per week?

Oz. per week: _____
(A standard pouch of tobacco contains 1 1/2 oz.)
Does not apply _____

4. How much pipe tobacco are you now smoking? Oz. per week _____
Not currently smoking a pipe. _____

5. Do you or did you inhale the pipe smoke?
1. _____ Never smoked
2. _____ Not at all
3. _____ Slightly
4. _____ Moderately
5. _____ Deeply

I. Have you ever smoked cigars regularly?
("YES" means more than 1 cigar a week for a year.)
1. Yes _____ 2. No _____

IF "YES", TO I1: (For persons who have ever smoked cigars)

1. How old were you when you started smoking cigars regularly? Age _____

2. If you have stopped smoking cigars completely, how old were you when you stopped?
Age stopped _____
Still smoking _____
Does not apply _____

3. On the average over the entire time you smoke cigars, how many cigars did you smoke per week?
Cigars per week _____
Does not apply _____

4. How many cigars are you smoking per week now?
Cigars per week _____
Not currently smoking cigars _____

5. Do you now or did you ever inhale the cigar smoke?
1. _____ Never smoked.
2. _____ Not at all.
3. _____ Slightly
4. _____ Moderately
5. _____ Deeply

Employee
Signature _____ Date ____ / ____ / ____