

**MINNESOTA OCCUPATIONAL HEALTH**

1661 St Anthony Avenue, St Paul, MN 55104  
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**PERIODIC 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 exposure: 1. Mild \_\_\_\_ 2. Moderate \_\_\_\_ 3. Severe \_\_\_\_

D. In the past year what was your:

1. Job occupation \_\_\_\_\_

2. Position/job title \_\_\_\_\_

**RECENT MEDICAL HISTORY**

A. Do you consider yourself to be in good health? 1. Yes \_\_\_\_ 2. No \_\_\_\_

If "NO", state reason \_\_\_\_\_

1. In the past, have you developed:

- 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 \_\_\_\_\_
- 7. Cancer? 1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

1 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 year, 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 C
- C. Did you produce phlegm with any of these chest illnesses? 1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_  
3. Does not apply \_\_\_\_\_
- D. In the last year, how many such illnesses with (increased)  
phlegm did you have which lasted a week or more? Number of illnesses \_\_\_\_\_

RESPIRATORY SYSTEM

In the past have you had:

- 1. Asthma: 1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ Comments on positive answer:  
\_\_\_\_\_
- 2. Bronchitis: 1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ Comments on positive answer:  
\_\_\_\_\_
- 3. Hay fever: 1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ Comments on positive answer:  
\_\_\_\_\_
- 4. Pneumonia 1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ Comments on positive answer:  
\_\_\_\_\_

5. Tuberculosis 1. Yes\_\_\_ 2. No\_\_\_ Comments on positive answer:

\_\_\_\_\_

6. Chest Surgery 1. Yes\_\_\_ 2. No\_\_\_ Comments on positive answer:

\_\_\_\_\_

7. Other lung problems 1. Yes\_\_\_ 2. No\_\_\_ Comments on positive answer:

8. Heart disease 1. Yes\_\_\_ 2. No\_\_\_ Comments on positive answer:

\_\_\_\_\_

9. Frequent colds 1. Yes\_\_\_ 2. No\_\_\_ Comments on positive answer:

\_\_\_\_\_

10. Chronic Cough 1. Yes\_\_\_ 2. No\_\_\_ Comments on positive answer:

\_\_\_\_\_

11. Shortness of breath with walking/climbing one flight of stairs 1. Yes\_\_\_ 2. No\_\_\_  
Comments on positive answer: \_\_\_\_\_

\_\_\_\_\_

DO YOU:

1. Wheeze 1. Yes\_\_\_ 2. No\_\_\_ Comment on positive answer:

\_\_\_\_\_

2. Cough up phlegm 1. Yes\_\_\_ 2. No\_\_\_ Comment on positive answer:

\_\_\_\_\_

3. Smoke Cigarettes 1. Yes\_\_\_ 2. No\_\_\_ Packs per day\_\_\_ How many Years\_\_\_

Date\_\_\_\_\_ Employee Signature\_\_\_\_\_