INITIAL HAZMAT/ASBESTOS MEDICAL QUESTIONNAIRE

DATE: ________ EW THE ____/ ________

NAME: ____ DOB: ________ EW THE ____/ ____

COMPANY: ____

OCCUPATIONAL HISTORY

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

B. If yes, have you ever worked for a year or more in any dusty job? ☐ Yes ☐ No
   Specific job/industry: ____________________ Total years worked: __________
   Was the 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 the 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)

E. Have you ever worked:
   1. In a mine? ☐ Yes ☐ No
   2. In a quarry? ☐ Yes ☐ No
   3. In a foundry? ☐ Yes ☐ No
   4. In a pottery? ☐ Yes ☐ No
   5. In a cotton, flax or hemp mill? ☐ Yes ☐ No
   6. With asbestos? ☐ Yes ☐ No

Past Medical History

A. Do you consider yourself to be in good health? ☐ Yes ☐ No
   If NO, State reason ____________________

B. Have you had any vision defects? ☐ Yes ☐ No
   If YES, state nature of defect ____________________

C. Have you had any hearing defects? ☐ Yes ☐ No
   If YES, state nature of defect ☐ Yes ☐ No

D. Are you suffering from or have you ever suffered from the following:
   1. Epilepsy (fits, seizures, convulsions)? ☐ Yes ☐ No
   2. Rheumatoid fever? ☐ Yes ☐ No
   3. Kidney disease? ☐ Yes ☐ No
   4. Bladder disease? ☐ Yes ☐ No
   5. Diabetes? ☐ Yes ☐ No
   6. Jaundice? ☐ Yes ☐ No

Chest Colds and Chest Illnesses

A. If you get a cold, does it usually go to your chest? ☐ Yes ☐ No
   (Usually means more than half the time)
B. 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
C. Did you produce phlegm with any of these chest illnesses? ☐ Yes ☐ No
D. In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more? # of illnesses: ______
E. Did you have any lung trouble before the age of 16? ☐ Yes ☐ No
F. Have you ever had any of the following:
   1. Attacks of bronchitis? ☐ Yes ☐ No
      - Was it confirmed by a doctor? ☐ Yes ☐ No
      - At what age was your first attack? Age: ______
   2. Pneumonia? (include bronchopneumonia) ☐ Yes ☐ No
      - Was it confirmed by a doctor? ☐ Yes ☐ No
      - At what age was your first attack? Age: ______
   3. Hay fever? ☐ Yes ☐ No
      - Was it confirmed by a doctor? ☐ Yes ☐ No
      - At what age was your first attack? Age: ______
G. Have you ever had chronic bronchitis? ☐ Yes ☐ No
   1. Do you still have it? ☐ Yes ☐ No
      - Was it confirmed by a doctor? ☐ Yes ☐ No
      - At what age was your first attack? Age: ______
H. Have you ever had emphysema? ☐ Yes ☐ No
   1. Do you still have it? ☐ Yes ☐ No
      - Was it confirmed by a doctor? ☐ Yes ☐ No
      - At what age was your first attack? Age: ______
I. Have you ever had asthma? ☐ Yes ☐ No
   2. Do you still have it? ☐ Yes ☐ No
      - Was it confirmed by a doctor? ☐ Yes ☐ No
      - At what age was your first attack? Age: ______

J. Have you ever had:
1. Any other chest illness? ☐ Yes ☐ No
If yes, please specify ______
2. Any chest operations? ☐ Yes ☐ No
If yes, please specify ______
3. Any chest injuries? ☐ Yes ☐ No
If yes, please specify ______

K. Has a doctor ever told you that you had heart trouble? ☐ Yes ☐ No
1. Have you ever had treatment for heart trouble in the past 10 years? ☐ Yes ☐ No

L. Has a doctor ever told you that you had high blood pressure? ☐ Yes ☐ No
1. Have you ever had treatment for high blood pressure (Hypertension) in the past 10 years? ☐ Yes ☐ No

M. When did you last have your chest X-Rayed? Year: ______
1. What was the outcome? ☐ normal ☐ abnormal
If abnormal, explain here: ______
2. Where did you last have your chest X-Rayed?(if known) ☐ Yes ☐ No

Family History

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

	Father			Mother		
	Yes	No	Unsure	Yes	No	Unsure
1. Chronic Bronchitis	☐	☐	☐	☐	☐	☐
2. Emphysema	☐	☐	☐	☐	☐	☐
3. Asthma	☐	☐	☐	☐	☐	☐
4. Lung Cancer	☐	☐	☐	☐	☐	☐
5. Other Chest Conditions	☐	☐	☐	☐	☐	☐
6. Is parent still alive?	☐	☐	☐	☐	☐	☐
7. Please specify	Age if living: ______			Age if living: ______		
	Age at death: ______			Age at death: ______		
	Don't Know: ______			Don't Know: ______		

Please specify cause of death: ______

Cough

A. Do you usually have a cough? ☐ Yes ☐ No
(Count a cough when you first smoke, or first going outdoors, excludes clearing of the throat.)

B. Do you usually cough as much as 4-6 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 night? ☐ Yes ☐ No

E. Do you usually cough like this on most days for 3 consecutive months

1661 St. Anthony Avenue, 2nd floor St. Paul, MN 55104
Phone: (651) 842-5300 Fax: (651) 842-5408
mohonline.com

or more during the year? ☐ Yes ☐ No

F. How many years have you had the cough? # of years ______ ☐ does not apply

G. Do you usually bring phlegm as much as twice a day, 4 or more days out of the week? ☐ Yes ☐ No

H. Do you usually bring up phlegm at all on getting up or first thing in the morning? ☐ Yes ☐ No

I. Do you usually bring up phlegm at all during the rest of the day or night? ☐ Yes ☐ No

J. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year? ☐ Yes ☐ No

K. For how many years have you had trouble with phlegm? # of years ______ ☐ does not apply

EPISODES OF COUGH & PHLEGM

A. Have you had periods or episodes of (increased) cough and phlegm lasting for 3 weeks or more each year? ☐ Yes ☐ No

B. For how long have you had at least 1 such episode per year? # of years ______ ☐ does not apply

WHEEZING

A. Does your chest ever sound wheezy or whistling? ☐ Yes ☐ No
   1. When you have a cold? ☐ Yes ☐ No
   2. Occasionally apart from colds? ☐ Yes ☐ No
   3. Most days or nights? ☐ Yes ☐ No

B. Have you ever had an attack of wheezing that has made you feel short of breath? ☐ Yes ☐ No

C. 1. How old were you when you had your first such attack? years ____ ☐ does not apply
   2. Have you had 2 or more such episodes? ☐ Yes ☐ No
   3. Have you ever required treatment for the attacks? ☐ Yes ☐ No

BREATHLESSNESS

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

____

B. Are you troubled by shortness of breath when hurrying or walking up a slight hill? ☐ Yes ☐ No
   1. Do you have to walk slower than people of your age on the level because of breathlessness? ☐ Yes ☐ No
   2. Do you ever have to stop for breath when walking at your own pace on the level? ☐ Yes ☐ No
   3. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level? ☐ Yes ☐ No
   4. Are you too breathless to leave the house, or on dressing or climbing stairs? ☐ Yes ☐ No

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.) ☐ Yes ☐ No

B. Do you now smoke cigarettes (as of one month ago)? ☐ Yes ☐ No

C. How old were you when you first started regular cigarette smoking? years ____ ☐ does not apply

D. If you have stopped smoking cigarettes completely, how old were you when you stopped? years ____ ☐ does not apply

E. How many cigarettes do you smoke a day now? # ________ ☐ does not apply

F. On the average of the entire time you have smoked, how many cigarettes have you smoked per day? # ________ ☐ does not apply

G. Do you now or did you ever inhale the cigarette smoke? ☐ does not apply
☐ Not at all
☐ Slightly
☐ Deeply

H. Have you ever smoked a pipe regularly? ☐ Yes ☐ No
If yes, please answer the following questions:
1. How old were you when you started to smoke a pipe regularly? years ____ ☐ does not apply
2. If you have stopped smoking a pipe completely, how old were you when you stopped? years ____ ☐ does not apply
3. On average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week? ☐ does not apply
Oz. per week:____________
(standard pouch contains 1.5 oz.)
4. How much pipe tobacco are you now smoking? ☐ does not apply
Oz. per week:____________
(standard pouch contains 1.5 oz.)
5. Do you or did you inhale the pipe smoke? ☐ does not apply
☐ Not at all
☐ Slightly
☐ Deeply

I. Have you ever smoked cigars regularly? ☐ Yes ☐ No
(Yes means more than 1 cigar a week for a year)
If yes, please answer the following questions:

1. How old were you when you started to smoke cigars regularly? Years_____ ☐ does not apply
2. If you have stopped smoking cigars completely, how old were you when you stopped? years ____ ☐ does not apply
3. On average over the entire time you smoked cigars, how Many did you smoke per week? ☐ does not apply
per week:____________

4. How many cigars are you now smoking? ☐ does not apply
per week:____________
5. Do you or did you inhale the cigar smoke? ☐ does not apply
☐ Not at all

☐ Slightly
☐ Deeply

Employee Signature ____ Date: ____________

1661 St. Anthony Avenue, 2nd floor St. Paul, MN 55104
Phone: (651) 842-5300 Fax: (651) 842-5408
mohonline.com
Integrated, Comprehensive Occupational Health Services