

Asbestos Surveillance: INITIAL MEDICAL QUESTIONNAIRE



WASHINGTON HEALTH SYSTEM
Occupational Medicine

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Name: _____	Social Security Number: _____
Present Occupation: _____	Clock Number: _____
Date of Birth (month, day, year): _____	Place of Birth _____
Plant/Company: _____	Telephone Number: _____
Address: _____	
(City)	(State)
	(Zip code)
Interviewer: _____	Today's Date: _____

DEMOGRAPHICS

Sex: Male Female

Marital Status: Single Married Widowed Divorced Separated

Race: White Hispanic Black Indian Asian Other: _____

What is the highest grade completed in school? _____
(For example 12 years is completion of high school)

OCCUPATIONAL HISTORY		
YES	NO	N/A
<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever worked full time (30 hours per week or more) for 6 months or more?
<input type="checkbox"/>	<input type="checkbox"/>	1a. If yes, have you ever worked for a year or more in any dusty job?
<input type="checkbox"/>	<input type="checkbox"/>	1b. If yes, specify job/industry: _____ - Total years worked: _____ - Was the dust exposure: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever been exposed to gas or chemical fumes in your work?
<input type="checkbox"/>	<input type="checkbox"/>	2a. If yes, specify job/industry _____ - Total years worked: _____ - Was the exposure: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/>	<input type="checkbox"/>	3. What has been your usual occupation or job -- the one you have worked at the longest? Job occupation _____ Number of years employed in this occupation _____ Position/job title _____ Business, field or industry _____

YES	NO	N/A		
			4. Have you ever worked in a:	State the years in which you have worked in any of these industries, e.g. 1960-1969)
<input type="checkbox"/>	<input type="checkbox"/>		Mine?	Time Period: _____
<input type="checkbox"/>	<input type="checkbox"/>		Quarry?	Time Period: _____
<input type="checkbox"/>	<input type="checkbox"/>		Foundry?	Time Period: _____
<input type="checkbox"/>	<input type="checkbox"/>		Pottery?	Time Period: _____
<input type="checkbox"/>	<input type="checkbox"/>		Cotton, Flax or Hemp mill?	Time Period: _____
<input type="checkbox"/>	<input type="checkbox"/>		With Asbestos?	Time Period: _____

PAST MEDICAL HISTORY		
YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	5. Do you consider yourself to be in good health? If "NO" state reason _____
<input type="checkbox"/>	<input type="checkbox"/>	6. Have you any defect of vision? If "YES" state nature of defect _____
<input type="checkbox"/>	<input type="checkbox"/>	7. Have you any hearing defect? If "YES" state nature of defect _____
		8. Are you suffering from or have you ever suffered from:
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (or fits, seizures, convulsions)?
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever?
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease?
<input type="checkbox"/>	<input type="checkbox"/>	Bladder disease?
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes?
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice?

CHEST COLDS AND CHEST ILLNESSES			
YES	NO	OTHER	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Don't get colds	9. If you get a cold, does it "usually" go to your chest (e.g., more than 1/2 the time)?
<input type="checkbox"/>	<input type="checkbox"/>		10. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	10a. If yes, did you produce phlegm with any of these chest illnesses?
			10b. In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more? ____ Number of illnesses ____ No such illnesses
<input type="checkbox"/>	<input type="checkbox"/>		11. Did you have any lung trouble before the age of 16?
			12. Have you ever had any of the following?
<input type="checkbox"/>	<input type="checkbox"/>		12a. Attacks of bronchitis ?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	12ai. If yes, was it confirmed by a doctor? At what age was your first attack? ____ Age in Years ____ Does Not Apply
<input type="checkbox"/>	<input type="checkbox"/>		12b. Pneumonia (include bronchopneumonia)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	12bi. If yes, was it confirmed by a doctor? At what age did you first have it? ____ Age in Years ____ Does Not Apply
<input type="checkbox"/>	<input type="checkbox"/>		12c. Hay Fever ?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	12ci. If yes, was it confirmed by a doctor At what age did it start? ____ Age in Years ____ Does Not Apply

YES	NO	OTHER	
<input type="checkbox"/>	<input type="checkbox"/>		13. Have you ever had chronic bronchitis ?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	13a. If yes, do you still have it?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	13b. If yes, was it confirmed by a doctor?
			At what age did it start? ____ Age in Years ____ Does Not Apply
<input type="checkbox"/>	<input type="checkbox"/>		14. Have you ever had emphysema ?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	14a. If yes, do you still have it?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	14b. If yes, was it confirmed by a doctor?
			At what age did it start? ____ Age in Years ____ Does Not Apply
<input type="checkbox"/>	<input type="checkbox"/>		15. Have you ever had asthma ?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	15a. If yes, do you still have it?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	15b. If yes, was it confirmed by a doctor?
			At what age did it start? ____ Age in Years ____ Does Not Apply 15c. If you no longer have it, at what age did it stop? ____ Age in Years ____ Does Not Apply
			16. Have you ever had?
<input type="checkbox"/>	<input type="checkbox"/>		16a. Any other chest illness ? If yes, please specify: _____
<input type="checkbox"/>	<input type="checkbox"/>		16b. Any chest operations ? If yes, please specify: _____
<input type="checkbox"/>	<input type="checkbox"/>		16c. Any chest injuries ? If yes, please specify: _____
<input type="checkbox"/>	<input type="checkbox"/>		17. Has a doctor ever told you that you had heart trouble ?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	17a. If yes, have you ever had treatment for heart trouble in the past 10 years?
<input type="checkbox"/>	<input type="checkbox"/>		18. Has a doctor told you that you had high blood pressure ?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not Applicable	18a. Have you had any treatment for high blood pressure (hypertension) in the past 10 years?
			19. When did you last have your chest X-rayed ? (Year) ____
			19a. Where did you last have your chest X-rayed (if known)? _____
			19b. What was the outcome? _____

FAMILY HISTORY

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

Chronic Lung Conditions:	Father			Mother		
	Yes	No	Don't know	Yes	No	Don't know
Chronic Bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other chest conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Don't know		Yes	No	Don't know
Is parent currently alive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify Age if Living							
Age at Death							
Cause of Death							

COUGH

YES	NO	Does Not Apply	
<input type="checkbox"/>	<input type="checkbox"/>		21. Do you usually have a cough? (INCLUDE a cough with first smoke or on first going out of doors. EXCLUDE clearing of throat.) If no, skip to question 21b.
<input type="checkbox"/>	<input type="checkbox"/>		21a. Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week?
<input type="checkbox"/>	<input type="checkbox"/>		21b. Do you usually cough at all on getting up or first thing in the morning?
<input type="checkbox"/>	<input type="checkbox"/>		21c. Do you usually cough at all during the rest of the day or at night?
			IF NO to all of the above (21 – 21c), check “Does Not Apply” and skip to #22. IF YES to any of the above (21 – 21c), answer the following:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21d. Do you usually cough like this on most days for 3 consecutive months or more during the year?
			21e. For how many years have you had the cough? ___ Number of years ___ Does not apply

PHLEGM

<input type="checkbox"/>	<input type="checkbox"/>		22. Do you usually bring up phlegm from your chest? (INCLUDE phlegm with the first smoke or on first going out of doors. INCLUDE swallowed phlegm. EXCLUDE phlegm from the nose.) If no, skip to 22b.
<input type="checkbox"/>	<input type="checkbox"/>		22a. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week?
<input type="checkbox"/>	<input type="checkbox"/>		22b. Do you usually bring up phlegm at all on getting up or first thing in the morning?
<input type="checkbox"/>	<input type="checkbox"/>		22c. Do you usually bring up phlegm at all on during the rest of the day or at night?
			IF NO to all of the above (22 – 22c), check “Does Not Apply” and skip to #23. IF YES to any of the above (22 – 22c), answer the following:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22d. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?
			22e. For how many years have you had trouble with phlegm? ___ Number of years ___ Does not apply

COUGH & PHLEGM

<input type="checkbox"/>	<input type="checkbox"/>		23. Have you had periods or episodes of cough or increased (for persons who usually have cough and/or phlegm) cough and phlegm lasting for 3 weeks or more each year?
			23a. If yes, for how long have you had at least 1 such episode per year? ___ Number of years ___ Does not apply

WHEEZING

YES	NO	Does Not Apply	
			24. Does your chest ever sound wheezy or whistling:
<input type="checkbox"/>	<input type="checkbox"/>		When you have a cold?
<input type="checkbox"/>	<input type="checkbox"/>		Occasionally apart from colds?
<input type="checkbox"/>	<input type="checkbox"/>		Most days or nights?

YES	NO	Does Not Apply	
			24a. If yes to any of the above, for how many years has this been present? ___ Number of years ___ Does not apply
<input type="checkbox"/>	<input type="checkbox"/>		25. Have you ever had an attack of wheezing that has made you feel short of breath?
			25a. If yes, how old were you when you had your first such attack? ___ Number of years ___ Does not apply
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you had 2 or more such episodes?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Have you ever required medicine or treatment for the(se) attack(s)?

BREATHLESSNESS

YES	NO	Does Not Apply	
			28. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question # 30. Nature of condition(s): _____ _____
<input type="checkbox"/>	<input type="checkbox"/>		29. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29a. If yes, do you have to walk slower than people of your age on the level because of breathlessness?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29b. Do you ever have to stop for breath when walking at your own pace on the level?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29c. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29d. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs?

TOBACCO SMOKING

YES	NO	Does Not Apply	
<input type="checkbox"/>	<input type="checkbox"/>		30. Have you ever smoked cigarettes ? (No 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.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30a. If yes, do you now smoke cigarettes (as of one month ago)?
			30b. How old were you when you first started regular cigarette smoking? ___ Age in years ___ Does not apply
			30c. If you have stopped smoking cigarettes completely, how old were you when you stopped? ___ Age stopped ___ Check if still smoking ___ Does not apply
			30d. How many cigarettes do you smoke per day now? ___ Cigarettes per day ___ Does not apply
			30e. On the average of the entire time you smoked, how many cigarettes did you smoke per day? ___ Cigarettes per day ___ Does not apply
			30f. Do or did you inhale the cigarette smoke? <input type="checkbox"/> Does not apply <input type="checkbox"/> Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Deeply

YES	NO	Does Not Apply	
<input type="checkbox"/>	<input type="checkbox"/>		31. Have you ever smoked a pipe regularly? (Yes means more than 12 oz. of tobacco in a lifetime.)
			31a. If yes, how old were you when you started to smoke a pipe regularly? ___ Age
			31b. If you have stopped smoking a pipe completely, how old were you when you stopped? ___ Age stopped ___ Check if still smoking pipe ___ Does not apply
			31c. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week? ___ oz. per week (a standard pouch of tobacco contains 1 1/2 oz.) ___ Does not apply
			31d. How much pipe tobacco are you smoking now? ___ oz. per week ___ Not currently smoking a pipe
			31e. Do you or did you inhale the pipe smoke? <input type="checkbox"/> Never smoked <input type="checkbox"/> Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Deeply
<input type="checkbox"/>	<input type="checkbox"/>		32. Have you ever smoked cigars regularly? (Yes means more than 1 cigar a week for a year)
			32a. If yes, how old were you when you started smoking cigars regularly? ___ Age
			32b. If you have stopped smoking a cigars completely, how old were you when you stopped? ___ Age stopped ___ Check if still smoking pipe ___ Does not apply
			32c. On the average over the entire time you smoked cigars, how much cigars did you smoke per week? ___ Cigars per week ___ Does not apply
			32d. How many cigars are you smoking per week now? ___ Cigars per week ___ Check if not smoking cigars currently
			32e. Do or did you inhale the cigar smoke? <input type="checkbox"/> Never smoked <input type="checkbox"/> Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Deeply

Proceed to next page.

