Asbestos Surveillance: ANNUAL MEDICAL QUESTIONNAIRE

WASHINGTON HEALTH SYSTEM
Occupational Medicine

95 Leonard Ave. • Bldg.1 • Suite 401• Washington, PA 15301 • WHS Greene Plaza • 220 Greene Plaza • Waynesburg, PA 15370 • P: 724-223-3528 F: 724-229-2401

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: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

OCCUPATIONAL HISTORY			
YES	**NO**	**N/A**	
☐	☐		1. In the past year, did you work full time (30 hours per week or more) for 6 months or more?
☐	☐	☐	1a. If yes, in the past year, did you work in a dusty job?
			1b. Was dust exposure: ☐ Mild ☐ Moderate ☐ Severe
☐	☐		1c. In the past year, were you exposed to gas or chemical fumes in your work?
			1d. If yes, was the exposure: ☐ Mild ☐ Moderate ☐ Severe
			1e. In the past year, what was your: Job/occupation? _____ Position/job title? _____

RECENT MEDICAL HISTORY			
YES	**NO**	**N/A**	
☐	☐		2. Do you consider yourself to be in good health? 2a. If NO, state reason _____
			2b. In the past year, have you developed:
☐	☐		i. Epilepsy?
☐	☐		ii. Rheumatic fever?
☐	☐		iii. Kidney disease?
☐	☐		iv. Bladder disease?
☐	☐		v. Diabetes?
☐	☐		vi. Jaundice?
☐	☐		vii. Cancer?

CHEST COLDS AND CHEST ILLNESSES			
YES	**NO**	**Other**	
☐	☐	☐ **Don't get colds**	3. If you get a cold, does it "usually" go to your chest? ("usually" means more than 1/2 the time)
☐	☐	☐ **Does not apply**	4. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
☐	☐	☐ **Does not apply**	4a. If yes, did you produce phlegm with any of these chest illnesses?
			4b. 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

RESPIRATORY SYSTEM			
5. In the past year have you had:	**YES**	**NO**	**Further Comment on Positive Answers**
i. Asthma	☐	☐	
ii. Bronchitis	☐	☐	
iii. Hay Fever	☐	☐	
iv. Other Allergies	☐	☐	
v. Pneumonia	☐	☐	
vi. Tuberculosis	☐	☐	
vii. Chest Surgery	☐	☐	
viii. Other Lung Problems	☐	☐	
ix. Heart Disease	☐	☐	
6. Do you have:	**YES**	**NO**	**Further Comment on Positive Answers**
i. Frequent colds	☐	☐	
ii. Chronic cough	☐	☐	
iii. Shortness of breath when walking	☐	☐	
iv. Shortness of breath when climbing one flight of stairs	☐	☐	
7. Do you:	**YES**	**NO**	**Further Comment on Positive Answers**
i. Wheeze	☐	☐	
ii. Cough up phlegm	☐	☐	
iii. Smoke cigarettes	☐	☐	_____ Packs per day ____ How many years

I certify that the information I have provided on the above medical history pages is complete, true, and accurate to the best of my knowledge. I understand that falsification or omission of any of the preceding information would misinform the medical practitioner of my medical history and potentially result in harm to myself, for which I would not hold the medical practitioner responsible. Additionally, I understand the care and information I received today is not a substitute for the care and information that I receive from my primary care physician. I agree that the Health Examination requested by my company is made with my consent and that the examination, test(s), and/or result(s) may be released to the above-named company and/or its representatives.

_____ _____ _____

Patient Signature Printed Date/Time

Technician / Staff explanation of any positive answer(s):

_____
_____
_____
_____
_____
_____

_____ _____ _____

Reviewer's Signature Printed Date/Time