

Asbestos Surveillance: ANNUAL 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: _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	

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

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

CHEST COLDS AND CHEST ILLNESSES			
YES	NO	Other	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 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)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 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?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	
iii. Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	
iv. Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
v. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
vi. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
vii. Chest Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
viii. Other Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	
ix. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
6. Do you have:	YES	NO	Further Comment on Positive Answers
i. Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	
iii. Shortness of breath when walking	<input type="checkbox"/>	<input type="checkbox"/>	
iv. Shortness of breath when climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	
7. Do you:	YES	NO	Further Comment on Positive Answers
i. Wheeze	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Cough up phlegm	<input type="checkbox"/>	<input type="checkbox"/>	
iii. Smoke cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	____ 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
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