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

Silica Surveillance: Medical Questionnaire

Name: _____
Birthdate: _____ Today's Date: _____

1. **Respirable crystalline silica, dust, and other agents affecting the respiratory system** – (applies to both work and non-work environments):
   a. Past exposure? □ yes □ no
   b. Current exposure? □ yes □ no
   c. Anticipated future exposure? □ yes □ no

   If yes, please explain: _____
   _____

2. A **Personal History** of previous or current:
   a. Respiratory system dysfunction? □ yes □ no
   b. Respiratory disease? □ yes □ no
   c. Tuberculosis (TB)? □ yes □ no
   d. Signs/Symptoms of respiratory disease (e.g., shortness of breath, cough, wheezing)? □ yes □ no
   e. Kidney disease □ yes □ no
   f. Cardiac disease □ yes □ no
   g. Connective tissue disorder/disease □ yes □ no
   h. Organ transplant □ yes □ no
   i. Diabetes □ yes □ no
   j. Other immune diseases □ yes □ no
   k. Other significant past medical conditions □ yes □ no

   If yes, please explain: _____
   _____

3. **Smoking history**:
   a. Current smoker? □ yes □ no
   b. Past smoker? □ yes □ no

   If yes:
   How much (daily basis)? _____
   For how long? _____

4. Any past or present routine **Medication** use? □ yes □ no
   If yes, please list those medications:_____
   _____

5. Have you undergone any **Surgical Procedures** and/or been **Hospitalized** for any reason? □ yes □ no
   If yes, please explain: _____
   _____
   _____

6. **Work History (please list prior employment and dates of that employment)**:

I certify that I have answered these questions truthfully and to the best of my knowledge.

_____ _____ _____
Patient Signature Printed Date

_____
Provider Signature