Washington Health System Occupational Medicine
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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