

§5208. Asbestos, Appendix D - Medical Questionnaires - Mandatory

Part 2

PERIODIC MEDICAL QUESTIONNAIRE:

1. NAME: _____
2. SOCIAL SECURITY NUMBER: _____
3. CLOCK NUMBER: _____
4. PRESENT OCCUPATION: _____
5. PLANT: _____
6. ADDRESS: _____
7. CITY: _____ ST: _____ ZIP CODE: _____
8. TELEPHONE NUMBER: (_____) _____ - _____ EXT. _____
9. INTERVIEWER: _____

10. DATE: ____ / ____ / ____
11. What is your marital status? 1. Single 2. Married 3. Widowed 4. Separated/Divorced

12. OCCUPATIONAL HISTORY

12A. In the past year, did you work full time (30 hours per week or more) for 6 months or more?: 1. Yes 2. No
IF YES TO 12A:
12B. In the past year, did you work in a dusty job? 1. Yes 2. No 3. Does Not Apply
12C. Was dust exposure: 1. Mild 2. Moderate 3. Severe
12D. In the past year, were you exposed to gas or chemical fumes in your work?: 1. Yes 2. No
12E. Was exposure: 1. Mild 2. Moderate 3. Severe
12F. In the past year, what was your:
1. Job/Occupation? _____
2. Position/Job Title? _____

13. RECENT MEDICAL HISTORY

13A. Do you consider yourself to be in good health? 1. Yes 2. No
If "No", state reason: _____
13B. In the past year, have you developed:
Epilepsy? 1. Yes 2. No
Rheumatic Fever? 1. Yes 2. No
Kidney Disease? 1. Yes 2. No
Bladder Disease? 1. Yes 2. No
Diabetes? 1. Yes 2. No
Jaundice? 1. Yes 2. No
Cancer? 1. Yes 2. No

14. CHEST COLDS AND CHEST ILLNESSES

14A. If you get a cold, does it "usually" go to your chest? (Usually means more than 1/2 the time) 1. Yes 2. No 3. Don't Get Colds
15A. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? 1. Yes 2. No 3. Does Not Apply
IF YES TO 15A:
15B. Did you produce phlegm with any of these chest illnesses? 1. Yes 2. No 3. Does Not Apply
15C. 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

16. RESPIRATORY SYSTEM

In the past year have you had: Further Comment on Positive Answers
Asthma Yes No _____
Bronchitis Yes No _____
Hay Fever Yes No _____
Other Allergies Yes No _____
Pneumonia Yes No _____
Tuberculosis Yes No _____
Chest Surgery Yes No _____
Other Lung Problems Yes No _____
Heart Disease Yes No _____
Do You Have:
Frequent Colds Yes No _____
Chronic Cough Yes No _____
Shortness Of Breath When Walking Or Climbing One Flight Of Stairs Yes No _____
Do you:
Wheeze Yes No _____
Cough Up Phlegm Yes No _____
Smoke Cigarettes Yes No _____ Packs Per Day _____ How Many Years _____

Signature _____ Date: ____ / ____ / ____