



# OCCUPATIONAL MEDICAL SERVICES

Your Partner in Employee Health

ASBESTOS EXPOSURE PART II - PERIODIC MEDICAL QUESTIONNAIRE									
IDENTIFICATION									
1. NAME (Last, First, Middle Initial)			2. SOCIAL SECURITY NO. (1 - 8)		3. CLOCK NO. (10 - 15)		4. PRESENT OCCUPATION		
5. NAME OF PLANT			6. STREET ADDRESS OF PLANT				7. PLANT CITY, STATE AND ZIP CODE		
8. TELEPHONE NO. <i>(include area code)</i>		9. NAME OF INTERVIEWER			10. DATE OF INTERVIEW <i>(16 - 21) (YYYYMMDD)</i>		11. MARITAL STATUS <i>(X one)</i>		
							a. SINGLE	b. MARRIED	
							c. WIDOWED	d. DIVORCED/SEPARATED	
MEDICAL DATA									
12. OCCUPATIONAL HISTORY				Yes	No	N/A	17. REMARKS <i>(*Use this section to further comment on positive answers)</i>		
a. IN THE PAST YEAR, DID YOU WORK FULL TIME (30 hours per week or more) FOR SIX MONTHS OR MORE?									
b. DID YOU WORK AT ANY DUSTY JOB DURING THE PAST YEAR? <i>*If Yes, complete c.</i>									
c. WAS EXPOSURE <i>(X one)</i>									
				MILD	MODERATE	SEVERE			
d. IN THE PAST YEAR, WERE YOU EXPOSED TO GAS OR CHEMICAL FUMES IN YOUR WORK? <i>*If Yes, complete e.</i>									
e. WAS EXPOSURE <i>(X one)</i>									
				MILD	MODERATE	SEVERE			
f. IN THE PAST YEAR, WHAT WAS YOUR									
(1) Job/Occupation									
(2) Position/Job Title									
13. MEDICAL HISTORY				Yes	No	N/A			
a. DO YOU CONSIDER YOURSELF TO BE IN GOOD HEALTH? <i>*If No, state reason.</i>						*			
b. IN THE PAST YEAR, HAVE YOU DEVELOPED									
(1) Epilepsy <i>(Or fits, seizures or convulsions)</i>									
(2) Rheumatic Fever									
(3) Kidney Disease									
(4) Bladder Disease									
(5) Diabetes									
(6) Jaundice									
14. IF YOU GET A COLD, DOES IT USUALLY GO TO YOUR CHEST? <i>(Usually means more than 1/2 of the time) *Don't get colds</i>						*			
15. CHEST ILLNESSES									
a. DURING THE PAST YEAR, HAVE YOU HAD ANY CHEST ILLNESSES THAT HAVE KEPT YOU OFF WORK, INDOORS AT HOME, OR IN BED?									
b. IF YES, DID YOU PRODUCE PHLEGM WITH ANY OF THESE ILLNESSES?									
c. IN THE LAST YEAR, HOW MANY SUCH ILLNESSES WITH INCREASED PHLEGM DID YOU HAVE WHICH LASTED A WEEK OR MORE? <i>(List number)</i>									
16. RESPIRATORY SYSTEM									
a. IN THE PAST YEAR, HAVE YOU HAD			Yes	No	b. DO YOU HAVE		Yes*	No	
(1) Asthma					(1) Frequent Colds				
(2) Bronchitis					(2) Chronic Cough				
(3) Hay Fever					(3) Shortness of breath when walking or climbing one flight of stairs				
(4) Other Allergies					c. DO YOU				
(5) Pneumonia					(1) Wheeze				
(6) Tuberculosis					(2) Cough up phlegm				
(7) Chest Surgery					(3) Smoke cigarettes <i>(If yes,)</i>				
(8) Other Lung Problems					Packs per day				
(9) Heart Disease					Number of years				
18. SIGNATURE								19. DATE SIGNED <i>(YYYYMMDD)</i>	