

Medical Asbestos Questionnaire; Mandatory - 1910.1001 App D
PART I
INITIAL MEDICAL QUESTIONNAIRE

- 1: Name: _____
- 2: Social Security Number: _____
- 3: Clock Number: _____
- 4: Present Occupation: _____
- 5: Plant: _____
- 6: Address: _____
- 7: Zip Code: _____
- 8: Phone: _____
- 9: Interviewer: _____
- 10: Date: _____
- 11: Date of Birth: _____
- 12: Place of Birth: _____
- 13: Sex: Male _____ Female _____
- 14: Marital Status: Single _____ Separated/Divorced _____ Married: _____ Widowed: _____
- 15: Race: White _____ Hispanic _____ Black _____ Indian _____ Asian _____ Other _____
- 16: What is the highest grade completed in school? _____

OCCUPATIONAL HISTORY

- 17: A. Have you ever worked full time (30 hours per week or more) for 6 months or more? Yes _____ No _____

IF YES TO 17A:

- B. Have you ever worked for a year or more in any dusty job? Yes _____ No _____

1 Specify Job/industry _____ Total Years Worked _____

2 Was dust exposure: Mild _____ Moderate _____ Severe _____

- C. Have you ever been exposed to gas or chemical fumes in your work? Yes _____ No _____

1 Specify Job/industry _____ Total Years Worked _____

2 Was exposure: Mild _____ Moderate _____ Severe _____

- D. What has been your usual occupation or job – the one you worked at the longest?

1 Job Occupation: _____

- 2 Number of years employed in this occupation _____
- 3 Position/ Job Title: _____
- 4 Business, field or industry: _____

(Record on lines the years in which you have worked in any of these industries, e.g. 1960-1969)

Have you ever worked:.....Yes.....No

- E. In a Mine? _____
- F. In a quarry? _____
- G. In a foundry? _____
- H. In a pottery? _____
- I. In a cotton, flax or hemp mill? _____
- J. With Asbestos? _____

PAST MEDICAL HISTORY

18: A. Do you consider yourself to be in good health? Yes _____ No _____

If "NO" state reason: _____

B. Have you any defect of vision? Yes _____ No _____

If "YES" state nature of defect: _____

C. Have you any hearing defect? Yes _____ No _____

If "NO" state reason: _____

D. Are you suffering from or have you ever suffered from:

- 1 Epilepsy (fits, seizures, convulsions)? Yes _____ No _____
- 2 Rheumatic fever? Yes _____ No _____
- 3 Kidney disease? Yes _____ No _____
- 4 Bladder disease? Yes _____ No _____
- 5 Diabetes? Yes _____ No _____
- 6 Jaundice? Yes _____ No _____

CHEST COLDS AND CHEST ILLNESSES

19: If you get a cold, does it "usually" go to your chest? (Usually means more than 1/2 the time.)

Yes _____ No _____ Don't get colds _____

20: A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?

Yes _____ No _____

IF YES TO 20A:

B. Did you produce phlegm with any of these chest illnesses? Yes _____ No _____ Does Not Apply _____

C. In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more?

Number of illnesses _____ No such illnesses _____

21: Did you have any lung trouble before the age of 16? Yes _____ No _____

22: Have you ever had any of the following?

A. Attacks of bronchitis? Yes _____ No _____

IF YES TO A:

1 Was it confirmed by a doctor? Yes _____ No _____ Does not apply _____

2 At what age was your first attack? Yes _____ No _____ Does not apply _____

B. Pneumonia (include bronchopneumonia)? Yes _____ No _____

IF YES TO B:

1 Was it confirmed by a doctor? Yes _____ No _____ Does not apply _____

2 At what age did you first have it? Age in years _____ Does not apply _____

C. Hay Fever? Yes _____ No _____

IF YES TO C:

1 Was it confirmed by a doctor? Yes _____ No _____ Does not apply _____

2 At what age did it start? Age in years _____ Does not apply _____

23: A. Have you ever had chronic bronchitis? Yes _____ No _____

IF YES TO 23A:

B. Do you still have it? Yes _____ No _____

C. Was it confirmed by a doctor? Yes _____ No _____ Does not apply _____

D. At what age did it start? Age in years _____ Does not apply _____

24: A. Have you ever had emphysema? Yes _____ No _____

IF YES TO 24A:

B. Do you still have it? Yes _____ No _____

C. Was it confirmed by a doctor? Yes _____ No _____ Does not apply _____

D. At what age did it start? Age in years _____ Does not apply _____

25: A. Have you ever had asthma? Yes _____ No _____

IF YES TO 25A:

- B. Do you still have it? Yes _____ No _____
- C. Was it confirmed by a doctor? Yes _____ No _____ Does not apply _____
- D. At what age did it start? Age in years _____ Does not apply _____
- E. If you no longer have it, at what age did it stop? Age Stopped _____ Does not apply _____

26: Have you ever had:

- A. Any other chest illness? Yes _____ No _____
If yes, please specify _____
- B. Any chest operations? Yes _____ No _____
If yes, please specify _____
- C. Any chest injuries? Yes _____ No _____
If yes, please specify _____

27: A. Has a doctor ever told you that you had heart trouble? Yes _____ No _____

IF YES TO 27A:

B. Have you ever had treatment for heart trouble in the past 10 years?

Yes _____ No _____ Does Not apply _____

28: A. Has a doctor told you that you had high blood pressure? Yes _____ No _____

IF YES TO 28A:

B. Have you had any treatment for high blood pressure (hypertension) in the past 10 years?

Yes _____ No _____ Does Not apply _____

29: When did you last have your chest X-rayed? (year) ____ ____ ____ ____

30: Where did you last have your chest X-rayed? (if known) _____

What was the outcome? _____

FAMILY HISTORY

31: Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

Key: 1=Yes, 2=No, 3=Don't Know

	Mother	Father
A. Chronic Bronchitis?	_____	_____
B. Emphysema?	_____	_____
C. Asthma?	_____	_____
D. Lung cancer?	_____	_____

	Mother	Father
E. Other chest conditions?	_____	_____
F. Is parent currently alive?	_____	_____
G. Please Specify:		
Age if Living	_____	_____
Age at Death	_____	_____
Don't Know	_____	_____
H. Please Specify cause of death:	_____	_____

COUGH

- 32: A. Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat) (If no, skip to question 32C.) Yes _____ No _____
- B. Do you usually cough as much as 4 to 6 times a day, 4 or more days out of the week? Yes _____ No _____
- C. Do you usually cough at all on getting up or first thing in the morning? Yes _____ No _____
- D. Do you usually cough at all during the rest of the day or at night? Yes _____ No _____

IF YES TO ANY OF THE ABOVE (32A, B, C, OR D), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO 34A.

- E. Do you usually cough like this on most days for 3 consecutive months or more during the year? Yes _____ No _____
- F. For how many years have you had the cough? No. of Years _____ Does not Apply _____
- 33: A. Do you usually bring up phlegm from your chest? (Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) (If no, skip to 33C.) Yes _____ No _____
- B. Do you usually bring up phlegm like this as much as twice a day, 4 or more days out of the week? Yes _____ No _____
- C. Do you usually bring up phlegm at all on getting up or first thing in the morning? Yes _____ No _____
- D. Do you usually bring up phlegm at all during the rest of the day or at night? Yes _____ No _____

IF YES TO ANY OF THE ABOVE (33A, B, C, OR D), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO 34A.

- E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year? Yes _____ No _____
- F. For how many years have you had trouble with phlegm? No. of Years _____ Does not Apply _____

EPISODES OF COUGH AND PHLEGM

- 34: A. Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year? (*for persons who usually have cough and /or phlegm) Yes _____ No _____
- B. For how long have you had at least 1 such episode per year? Yes _____ No _____

WHEEZING

- 35: A. Does your chest ever sound wheezy or whistling? Yes _____ No _____

- 1 When you have a cold? Yes _____ No _____
- 2 Occasionally, apart from colds? Yes _____ No _____
- 3 Most days or nights? Yes _____ No _____

IF YES TO 1, 2, OR 3 IN 35A:

- B. For how many years has this been present? No. of years _____ Does not apply _____
- 36: A. Have you ever had an attack of wheezing that has made you feel short of breath? Yes _____ No _____

IF YES TO 36A:

- B. How old were you when you had your first such attack? Age in years _____ Does not apply _____
- C. Have you had 2 or more such episodes? Yes _____ No _____ Does not apply _____
- D. Have you ever required medicine or treatment for the(se) attack(s)? Yes _____ No _____ Does not apply _____

BREATHLESSNESS

- 37: If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 39A.

Nature of condition(s) _____

- 38: A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill? Yes _____ No _____

IF YES TO 38A:

- B. Do you have to walk slower than people of your age on the level because of breathlessness?
Yes _____ No _____ Does not apply _____
- C. Do you ever have to stop for breath when walking at your own pace on the level?
Yes _____ No _____ Does not apply _____

TOBACCO SMOKING

- 39: A. Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or 12oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year.) Yes _____ No _____
- B. Do you now smoke cigarettes (as of one month ago?) Yes _____ No _____

IF YES TO 39A:

- C. How old were you when you first started regular cigarette smoking? Age in years _____ Does not apply _____
- D. If you have stopped smoking cigarettes completely, how old were you when you stopped?
Age Stopped _____ Check if still smoking _____ Does not apply _____
- E. How many cigarettes do you smoke per day now? Cigarettes per day _____ Does not apply _____
- F. On the average of the entire time you smoked, how many cigarettes did you smoke per day?
Cigarettes per day _____ Does not apply _____

G. Do or did you inhale the cigarette smoke?

Does not apply _____ Not at all _____ Slightly _____ Moderately _____ Deeply _____

40: A. Have you ever smoked a pipe regularly? (Yes means more than 12 oz of tobacco in a lifetime.) Yes _____ No _____

IF YES TO 40A: FOR PERSONS WHO HAVE EVER SMOKED A PIPE

B. 1. How old were you when you started to smoke a pipe regularly? Age _____

2. If you have stopped smoking a pipe completely, how old were you when you stopped?

Age stopped _____ Check if still smoking pipe _____ Does not apply _____

C. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week?

_____ oz. per week (a standard pouch of tobacco contains 1 ½ oz.) or Does not apply _____

D. How much pipe tobacco are you smoking now? _____ oz. per week _____ Not currently smoking a pipe

E. Do you or did you inhale the pipe smoke?

Never smoked _____ Not at all _____ Slightly _____ Moderately _____ Deeply _____

41: A. Have you ever smoked cigars regularly? (Yes means more than 1 cigar a week for a year.) Yes _____ No _____

IF YES TO 41A: FOR PERSONS WHO HAVE EVER SMOKED CIGARS

B. 1. How old were you when you first started regular cigar smoking? Age in years _____ Does not apply _____

2. If you have stopped smoking cigars completely, how old were you when you stopped?

Age Stopped _____ Check if still smoking _____ Does not apply _____

C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week?

Cigars per week _____ Not currently smoking cigars _____

D. How many cigars are you smoking per week now? Cigars per week _____ Check if not smoking cigars _____

E. Do you or did you inhale the cigar smoke?

Never smoked _____ Not at all _____ Slightly _____ Moderately _____ Deeply _____

Signature _____

Date _____

[57 FR 24330, JUNE 8, 1992; 59 FR 40964, AUG. 10, 1994]

Mail completed questionnaire to:
Sparrow Occupational Health Services
1322 East Michigan Avenue, Suite 101
Lansing, MI 48912

OR

Fax completed questionnaire to:
Sparrow Occupational Health Services
Attention: Asbestos Questionnaire Review
Fax # 517-364-3914