

Medical Asbestos Questionnaire; Mandatory - 1910.1001 App D
PART II
PERIODIC 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: Marital Status: Single: _____ Separated/Divorced: _____ Married: _____ Widowed: _____

OCCUPATIONAL HISTORY

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

IF YES TO 12A:

- B. In the past year, did you work in a dusty job? Yes _____ No _____ Does not apply _____

- C. Was dust exposure: Mild _____ Moderate _____ Severe _____

- D. In the past year, have you been exposed to gas or chemical fumes in your work? Yes _____ No _____

- E. Was exposure: Mild _____ Moderate _____ Severe _____

- F. In the past year, what was your:

1. Job Occupation: _____
2. Position/ Job Title: _____

RECENT MEDICAL HISTORY

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

If "NO" state reason: _____

- B. In the past year, have you developed:

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 _____
7. Cancer? Yes _____ No _____

CHEST COLDS AND CHEST ILLNESSES

14. If you get a cold, does it "usually" go to your chest? (Usually means more than ½ the time.)

Yes _____ No _____ Don't get colds _____

15: A. During the past year, have you had any chest illnesses that have kept you off work, indoors or in bed?

Yes _____ No _____ Does not apply _____

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

C. In the past year, how many such illnesses with (increased phlegm did you have which lasted a week or more?

Number of illnesses _____ No illness _____

16: In the past year have you had any of the following?

- A. Bronchitis? Yes _____ No _____ Comment _____
- B. Pneumonia (include bronchopneumonia)? Yes _____ No _____ Comment _____
- C. Hay Fever? Yes _____ No _____ Comment _____
- D. Asthma? Yes _____ No _____ Comment _____
- E. Tuberculosis? Yes _____ No _____ Comment _____
- F. Other Allergies? Yes _____ No _____ Comment _____
- G. Chest Surgery? Yes _____ No _____ Comment _____
- H. Other Lung Problems? Yes _____ No _____ Comment _____
- I. Heart Disease? Yes _____ No _____ Comment _____
- J. Frequent Colds? Yes _____ No _____ Comment _____
- K. Chronic Cough? Yes _____ No _____ Comment _____
- L. Shortness of Breath when walking or climbing one flight of stairs? Yes _____ No _____
Comment _____
- M. Wheezing? Yes _____ No _____ Comment _____
- N. Cough up phlegm? Yes _____ No _____ Comment _____
- O. Smoke Cigarettes? Yes _____ No _____ Packs per day _____ How many years _____

Signature: _____ Date: _____

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