

**ASBESTOS EXPOSURE
PART II - PERIODIC MEDICAL QUESTIONNAIRE**

IDENTIFICATION

1. NAME <i>(Last, First, Middle Initial)</i>	2. SOCIAL SECURITY NO. <i>(1 - 9)</i>	3. CLOCK NO. <i>(10 - 15)</i>	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> <input type="checkbox"/> a. SINGLE <input type="checkbox"/> b. MARRIED <input type="checkbox"/> c. WIDOWED <input type="checkbox"/> 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 <i>(30 hours per week or more)</i> 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>				
<input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> 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>				
<input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> 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
(1) Asthma			(1) Frequent Colds	No
(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>