

OSHA - ASBESTOS INITIAL MEDICAL SURVEILLANCE QUESTIONNAIRE

This mandatory appendix contains the medical questionnaires that must be administered to all employees who are exposed to asbestos above permissible exposure limit, and who will therefore be included in their employer's medical surveillance program. Part 1 of the appendix contains the Initial Medical Questionnaire, which must be obtained for all new hires who will be covered by the medical surveillance requirements.

1. NAME _____
2. SOCIAL SECURITY NUMBER # _____
3. CLOCK NUMBER _____
4. PRESENT OCCUPATION _____
5. PLANT _____
6. ADDRESS _____
7. _____ (Zip Code) _____
8. TELEPHONE NUMBER _____
9. INTERVIEWER _____
10. DATE _____
11. Date of Birth _____
12. Place of Birth _____
13. Sex
1. Male _____
2. Female _____
14. What is your marital status?
1. Single _____
2. Married _____
3. Widowed _____
4. Separated/Divorces _____
15. Race
1. White _____ 4. Hispanic _____
2. Black _____ 5. Indian _____
3. Asian _____ 6. Other _____
16. What is the highest grade completed in school? _____
(For example 12 years is completion of high school)

OCCUPATIONAL HISTORY

- 17A. Have you ever worked full time (30 hours per week or more) for 6 months or more?
1. Yes _____ 2. No _____

IF YES TO 17A:

- B. Have you ever worked for a year or more in any dusty job?
1. Yes _____ 2. No _____ 3. Does Not Apply _____

Specify job/industry _____ Total Years Worked _____
Was dust exposure: 1. Mild _____ 2. Moderate _____ 3. Severe _____

- C. Have you ever been exposed to gas or chemical fumes in your work?
1. Yes _____ 2. No _____

Specify job/industry _____ Total Years Worked _____
Was dust exposure: 1. Mild _____ 2. Moderate _____ 3. Severe _____

- D. What has been your usual occupation or job -- the one you have 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?	_____	_____

18. **PAST MEDICAL HISTORY** YES NO

A. Do you consider yourself to be in good health? _____
If "NO" state reason _____

B. Have you any defect of vision? _____
If "YES" state nature of defect _____

C. Have you any hearing defect? _____
If "YES" state nature of defect _____

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

- a. Epilepsy (or fits, seizures, convulsions)? _____
- b. Rheumatic fever? _____
- c. Kidney disease? _____
- d. Bladder disease? _____
- e. Diabetes? _____
- f. Jaundice? _____

19. **CHEST COLDS AND CHEST ILLNESSES**

19A. 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 ___

20A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
1. Yes ___ 2. No ___
IF YES TO 20A:

B. Did you produce phlegm with any of these chest illnesses?
1. Yes ___ 2. No ___ 3. 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?
1. Yes ___ 2. No ___

22. Have you ever had any of the following?

1A. Attacks of bronchitis?
1. Yes ___ 2. No ___
IF YES TO 1A:

B. Was it confirmed by a doctor?
1. Yes ___ 2. No ___ 3. Does Not Apply ___

C. At what age was your first attack?
Age in Years ___ Does Not Apply ___

2A. Pneumonia (include bronchopneumonia)?
1. Yes ___ 2. No ___
IF YES TO 2A:

B. Was it confirmed by a doctor?
1. Yes ___ 2. No ___ 3. Does Not Apply ___

C. At what age did you first have it?
Age in Years ___ Does Not Apply ___

3A. Hay Fever?
1. Yes ___ 2. No ___
IF YES TO 3A:

B. Was it confirmed by a doctor?
1. Yes ___ 2. No ___ 3. Does Not Apply ___

C. At what age did it start?
Age in Years ___ Does Not Apply ___

23A. Have you ever had chronic bronchitis?
1. Yes ___ 2. No ___
IF YES TO 23A:

B. Do you still have it?
1. Yes ___ 2. No ___ 3. Does Not Apply ___

C. Was it confirmed by a doctor?
1. Yes ___ 2. No ___ 3. Does Not Apply ___

D. At what age did it start?
Age in Years ___ Does Not Apply ___

24A. Have you ever had emphysema?
1. Yes ___ 2. No ___
IF YES TO 24A:

B. Do you still have it?
1. Yes ___ 2. No ___ 3. Does Not Apply ___

C. Was it confirmed by a doctor?
1. Yes ___ 2. No ___ 3. Does Not Apply ___

D. At what age did it start?
Age in Years ___ Does Not Apply ___

25A. Have you ever had asthma?
1. Yes ___ 2. No ___
IF YES TO 25A:

B. Do you still have it?
1. Yes ___ 2. No ___ 3. Does Not Apply ___

C. Was it confirmed by a doctor?
1. Yes ___ 2. No ___ 3. 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 stopped?
Age stopped ___ Does Not Apply ___

26. Have you ever had:

A. Any other chest illness?
1. Yes ___ 2. No ___

If yes, please specify _____

B. Any chest operations?

1. Yes ___ 2. No ___

If yes, please specify _____

C. Any chest injuries?

1. Yes ___ 2. No ___

If yes, please specify _____

27A. Has a doctor ever told you that you had heart trouble?

1. Yes ___ 2. No ___

IF YES TO 27A:

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

1. Yes ___ 2. No ___ 3. Does Not Apply ___

28A. Has a doctor told you that you had high blood pressure?

1. Yes ___ 2. No ___

IF YES TO 28A:

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

1. Yes ___ 2. No ___ 3. 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:

	FATHER			MOTHER		
	1. Yes	2. No	3. Don't know	1. Yes	2. No	3. Don't know

A. Chronic Bronchitis?	___	___	___	___	___	___
B. Emphysema?	___	___	___	___	___	___
C. Asthma?	___	___	___	___	___	___
D. Lung cancer?	___	___	___	___	___	___
E. Other chest conditions?	___	___	___	___	___	___
F. Is parent currently alive	___	___	___	___	___	___

G. Please Specify	___	Age if Living	___	Age if Living
	___	Age at Death	___	Age at Death
	___	Don't Know	___	Don't Know

H. Please specify cause of death

COUGH

32A. Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.)

1. Yes ___ 2. No ___
(If no, skip to question 32C.)

B. Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week?

1. Yes ___ 2. No ___

C. Do you usually cough at all on getting up or first thing in the morning?

1. Yes ___ 2. No ___

D. Do you usually cough at all during the rest of the day or at night?

1. Yes ___ 2. No ___

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

E. Do you usually cough like this on most days for 3 consecutive months or more during the year?

1. Yes ___ 2. No ___ 3. Does not apply ___

F. For how many years have you had the cough?

Number of years ___ Does not apply ___

33A. 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)

1. Yes ___ 2. No ___

B. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week?

1. Yes ___ 2. No ___

C. Do you usually bring up phlegm at all on getting up or first thing in the morning?

1. Yes ___ 2. No ___

D. Do you usually bring up phlegm at all on during the rest of the day or at night?

1. Yes ___ 2. 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?

1. Yes ___ 2. No ___ 3. Does not apply ___

F. For how many years have you had trouble with phlegm?

Number of years ___ Does not apply ___

EPISODES OF COUGH AND PHLEGM

34A. 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)

1. Yes ___ 2. No ___

IF YES TO 34A

B. For how long have you had at least 1 such episode per year?

Number of years ___ Does not apply ___

WHEEZING

35A. Does your chest ever sound wheezy or whistling

1. When you have a cold?

1. Yes ___ 2. No ___

2. Occasionally apart from colds?

1. Yes ___ 2. No ___

3. Most days or nights?

1. Yes ___ 2. No ___

IF YES TO 1, 2, or 3 in 35A

B. For how many years has this been present?

Number of years ___ Does not apply ___

36A. Have you ever had an attack of wheezing that has made you feel short of breath?

1. Yes ___ 2. 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?

1. Yes ___ 2. No ___ 3. Does not apply ___

D. Have you ever required medicine or treatment for the(se) attack(s)?

1. Yes ___ 2. No ___ 3. 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) _____

38A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

1. Yes ___ 2. No ___

IF YES TO 38A

B. Do you have to walk slower than people of your age on the level because of breathlessness?

1. Yes ___ 2. No ___ 3. Does not apply ___

C. Do you ever have to stop for breath when walking at your own pace on the level

1. Yes ___ 2. No ___ 3. Does not apply ___

D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?

1. Yes ___ 2. No ___ 3. Does not apply ___

E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs?

1. Yes ___ 2. No ___ 3. Does not apply ___

TOBACCO SMOKING

39A. Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year.)

1. Yes ___ 2. No ___

IF YES TO 39A

B. Do you now smoke cigarettes (as of one month ago)

1. Yes ___ 2. No ___ 3. Does not apply ___

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?

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?

- 1. Does not apply _____
- 2. Not at all _____
- 3. Slightly _____
- 4. Moderately _____
- 5. Deeply _____

40A. Have you ever smoked a pipe regularly? (Yes means more than 12 oz. of tobacco in a lifetime.)

1. Yes ___ 2. No ___

IF YES TO 40A:

