OSHA - ASBESTOS PERIODICAL MEDICAL QUESTIONNAIRE

This abbreviated Periodical Medical Questionnaire must be administered to all employees who are provided periodic medical examinations under the medical surveillance provisions of the OSHA Asbestos Standard.

PLEASE PRINT

1. NAME _____
2. SOCIAL SECURITY # ___ ___ ___ ___ ___ ___ ___ ___ ___
3. CLOCK NUMBER ___ ___ ___ ___ ___ ___ ___
4. PRESENT OCCUPATION _____
5. PLANT _____
6. ADDRESS _____
7. _____ Zip Code
8. TELEPHONE NUMBER _____
9. INTERVIEWER _____
10. DATE _____
11. What is your marital status? 1.Single 2.Married 3.Widowed 4.Separated 5.Divorced
12. **OCCUPATIONAL HISTORY**

12A. In the past year, did you work full time (30 hours per week or more) for 6 months or more?
1. Yes ___ 2. No ___

IF YES TO 12A:

12B. In the past year, did you work in a dusty job?
1. Yes ___ 2. No ___ 3. Does not Apply ___

12C. Was dust exposure: 1. Mild ___ 2. Moderate ___ 3. Severe ___

12D. In the past year, were you exposed to gas or chemical fumes in your work?
1. Yes ___ 2. No ___

12E. Was exposure: 1. Mild ___ 2. Moderate ___ 3. Severe ___

12F. In the past year, what was your: 1. Job/occupation? _____
2. Position/job title? _____

13. **RECENT MEDICAL HISTORY**

13A. Do you consider yourself to be in good health? 1. Yes ___ 2. No ____
If NO, state reason _____

13B. In the past year, have you developed:

	Yes	No
Epilepsy?	___	___
Rheumatic fever?	___	___
Kidney disease?	___	___
Bladder disease?	___	___
Diabetes?	___	___
Jaundice?	___	___
Cancer?	___	___

14. **CHEST COLDS AND CHEST ILLNESSES**

14A. 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 ___

15A. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
1. Yes ___ 2. No ___ 3. Does not Apply ____

IF YES TO 15

15B. Did you produce phlegm with any of these chest illnesses?
1. Yes ___ 2. No ___ 3. Does Not Apply ___

15C. In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more?
Number of illnesses ___ No such illnesses ___

16. **RESPIRATORY SYSTEM**

In the past year have you had:

	Yes or No	**Further Comment on Positive Answers**
Asthma	_____	
Bronchitis	_____	
Hay Fever	_____	
Other Allergies	_____	
Pneumonia	_____	
Tuberculosis	_____	
Chest Surgery	_____	
Other Lung Problems	_____	
Heart Disease	_____	
Do you have:	**Yes or No**	**Further Comment on Positive Answers**
Frequent colds	_____	
Chronic cough	_____	

Shortness of breath when walking or climbing one flight of stairs: _____

Do you:

Wheeze _____
Cough up phlegm _____
Smoke cigarettes _____ Packs per day ____ How many years ___

Date _____ Signature _____