Appendix D to §1910.1001 - Medical Questionnaires - Mandatory

Part 2

PERIODIC MEDICAL QUESTIONNAIRE:

1. NAME: _____
2. CLOCK NUMBER: _____
3. PRESENT OCCUPATION: _____
4. PLANT: _____
5. ADDRESS: _____
6. ZIP CODE: _____
7. TELEPHONE NUMBER: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___, EXT. ___ ___ ___ ___
8. INTERVIEWER: _____
9. DATE: ___ ___ / ___ ___ / ___ ___
10. What is your marital status? 1. ○ Single 2. ○ Married 3. ○ Widowed 4. ○ Separated/Divorced
11. **OCCUPATIONAL HISTORY**

11A. 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 11A:

11B. In the past year, did you work in a dusty job? 1. ○ Yes 2. ○ No 3. ○ Does Not Apply

11C. Was dust exposure: 1. ○ Mild 2. ○ Moderate 3. ○ Severe

11D. In the past year, were you exposed to gas or chemical fumes in your work?: 1. ○ Yes 2. ○ No

11E. Was exposure: 1. ○ Mild 2. ○ Moderate 3. ○ Severe

11F. In the past year, what was your:

Job/Occupation? _____

Position/Job Title? _____

12. **RECENT MEDICAL HISTORY**

12A. Do you consider yourself to be in good health? 1. ○ Yes 2. ○ No

If "No", state reason: _____

12B. In the past year, have you developed:

Epilepsy?	○ Yes	○ No
Rheumatic Fever?	○ Yes	○ No
Kidney Disease?	○ Yes	○ No
Bladder Disease?	○ Yes	○ No
Diabetes?	○ Yes	○ No
Jaundice?	○ Yes	○ No
Cancer?	○ Yes	○ No

13. **CHEST COLDS AND CHEST ILLNESSES**

13A. 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

14A. 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 14A:

14B. Did you produce phlegm with any of these chest illnesses? 1. ○ Yes 2. ○ No 3. ○ Does Not Apply

14C. 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

15. **RESPIRATORY SYSTEM**

In the past year have you had:			Further Comment on Positive Answers
Asthma	○ Yes	○ No	
Bronchitis	○ Yes	○ No	
Hay Fever	○ Yes	○ No	
Other Allergies	○ Yes	○ No	
Pneumonia	○ Yes	○ No	
Tuberculosis	○ Yes	○ No	
Chest Surgery	○ Yes	○ No	
Other Lung Problems	○ Yes	○ No	
Heart Disease	○ Yes	○ No	
Do You Have:			
Frequent Colds	○ Yes	○ No	
Chronic Cough	○ Yes	○ No	
Shortness Of Breath When Walking Or Climbing One Flight Of Stairs	○ Yes	○ No	
Do you:			
Wheeze	○ Yes	○ No	
Cough Up Phlegm	○ Yes	○ No	
Smoke Cigarettes	○ Yes	○ No	___ ___ Packs Per Day ___ ___ How Many Years

_____ Date: ___ ___ / ___ ___ / ___ ___

Signature