

**INITIAL MEDICAL QUESTIONNAIRE  
PART 1**

**Confidential**

1. Name \_\_\_\_\_
2. Social Security Number \_\_\_\_\_
3. Clock Number (if applicable) \_\_\_\_\_
4. A. Asbestos Worker Certification Number (if Applicable) \_\_\_\_\_  
B. Date of Certification \_\_\_\_\_
5. Plant or Employer \_\_\_\_\_
6. Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Zip Code)
7. Telephone Number \_\_\_\_\_
8. Interviewer (if Applicable) \_\_\_\_\_
9. Date \_\_\_\_\_
10. Date of Birth \_\_\_\_\_
11. Place of Birth \_\_\_\_\_
12. Sex:     Male                      Female   (circle one)
13. What is your marital status?  
    a. Single                      \_\_\_\_\_  
    b. Married                     \_\_\_\_\_  
    c. Widowed                    \_\_\_\_\_  
    d. Separated/  
        Divorced                    \_\_\_\_\_
14. Race:  
    a. White                      \_\_\_\_\_  
    b. Black                        \_\_\_\_\_  
    c. Asian                        \_\_\_\_\_  
    d. Hispanic                    \_\_\_\_\_  
    e. Indian                       \_\_\_\_\_  
    f. Other                        \_\_\_\_\_

15. What is the highest grade completed in school? \_\_\_\_\_  
 (For example, 12 years is completion of high school)

**OCCUPATIONAL HISTORY**

16. A. Have you ever worked full time (30 hours per week or more) for 6 months or more? a. Yes \_\_\_  
 b. No \_\_\_  
**IF NO TO 16A, GO TO QUESTION 17**  
**IF YES TO 16A:**

B. Have you ever worked for a year or more in any dusty job? a. Yes \_\_\_  
 b. No \_\_\_

If yes, Specify job/industry \_\_\_\_\_ Total years worked \_\_\_\_\_

Was dust exposure: a. Mild \_\_\_ b. Moderate \_\_\_ c. Severe \_\_\_

C. Have you ever been exposed to gas or chemical fumes in your work? a. Yes \_\_\_  
 b. No \_\_\_

If yes, Specify job/industry \_\_\_\_\_ Total years worked \_\_\_\_\_

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 \_\_\_\_\_

E. Have you ever worked: If yes, list years, e.g., 1989-1994

	Yes	No	From year	To year
1. In a mine?.....	[ ]	[ ]	_____	_____
2. In a quarry?.....	[ ]	[ ]	_____	_____
3. In a foundry?.....	[ ]	[ ]	_____	_____
4. In a pottery?.....	[ ]	[ ]	_____	_____
5. In a cotton, flax, or hemp mill? .....	[ ]	[ ]	_____	_____
6. With asbestos, tremolite, anthophyllite, or actinolite? [ ] [ ]	[ ]	[ ]	_____	_____

7. Have you ever worked in an environment where others were tearing out, cutting through or handling asbestos? Yes No  
[ ] [ ]

F. If you answered Yes to E 6. or E 7., please answer F 1. through F 13.  
 If you answered No to E 6. or E 7., please go on to question 17.

1. How long have you worked with asbestos or worked in an environment where asbestos was being worked with or torn out?  
 Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

2. What percentage of the total time spent working with asbestos were you actually exposed to asbestos dust? (Choose one)  
 0-15% \_\_\_\_\_ 16-25% \_\_\_\_\_ 26-50% \_\_\_\_\_ 51-75% \_\_\_\_\_ 76-100% \_\_\_\_\_

3. Have you ever spray-applied asbestos onto a surface? ..... Yes No  
 [ ] [ ]  
 If yes, how long? Years \_\_\_\_\_ Months \_\_\_\_\_

4. Have you ever demolished or torn out asbestos without wetting it? ..... [ ] [ ]  
 If yes, how long? Years \_\_\_\_\_ Months \_\_\_\_\_

5. Have you ever shoveled or emptied sacks of dry asbestos powder? ..... [ ] [ ]  
 If yes, how long? Years \_\_\_\_\_ Months \_\_\_\_\_

6. Have you ever worked in a plant manufacturing asbestos products? ..... [ ] [ ]  
 If yes, how long? Years \_\_\_\_\_ Months \_\_\_\_\_

7. Have you ever worked in an asbestos mine? ..... [ ] [ ]  
 If yes, how long? Years \_\_\_\_\_ Months \_\_\_\_\_

8. Have you ever worked in shipyards? ..... [ ] [ ]  
 If yes, how long? Years \_\_\_\_\_ Months \_\_\_\_\_

9. Have you ever been exposed to asbestos as a:

a. insulator	Yes [ ]	No [ ]	Don't Know [ ]
b. pipefitter	Yes [ ]	No [ ]	Don't Know [ ]
c. boilermaker	Yes [ ]	No [ ]	Don't Know [ ]
d. carpenter	Yes [ ]	No [ ]	Don't Know [ ]
e. asbestos abatement worker	Yes [ ]	No [ ]	Don't Know [ ]
f. demolition worker	Yes [ ]	No [ ]	Don't Know [ ]
g. other	Yes [ ]	No [ ]	Don't Know [ ]

please describe other \_\_\_\_\_

10. Did you wear your asbestos work clothes home?  
 ALWAYS \_\_\_\_\_ SOMETIMES \_\_\_\_\_ NEVER \_\_\_\_\_
11. Did you shower before leaving work after working with or around asbestos?  
 ALWAYS \_\_\_\_\_ SOMETIMES \_\_\_\_\_ NEVER \_\_\_\_\_
12. Did you go through decontamination (including removing clothing in an equipment room, showering in a separate shower area followed by putting on street clothes in a clean room) before leaving your asbestos work site?  
 ALWAYS \_\_\_\_\_ SOMETIMES \_\_\_\_\_ NEVER \_\_\_\_\_
13. During the time you have been exposed to asbestos Yes No  
 in the past, did you wear protective equipment? ..... [ ] [ ]

**If yes, note which of the following types of equipment you used and how much of the time that you were exposed to asbestos did you use the equipment.**

Mark if used at all:	Less than 1/2	About 1/2	About 3/4	All the Time
[ ] disposable half face respirator	[ ]	[ ]	[ ]	[ ]
[ ] rubber half face respirator	[ ]	[ ]	[ ]	[ ]
[ ] full face respirator	[ ]	[ ]	[ ]	[ ]
[ ] powered air purifying respirator	[ ]	[ ]	[ ]	[ ]
[ ] supplied air respirator	[ ]	[ ]	[ ]	[ ]
[ ] protective clothing	[ ]	[ ]	[ ]	[ ]

14. Were you ever exposed to asbestos that was visibly suspended Yes No  
 in the air while you were not wearing a respirator? ..... [ ] [ ]

**PAST MEDICAL HISTORY**

17. A. Do you consider yourself to be in good health? ..... Yes No  
 If NO, state reason \_\_\_\_\_ [ ] [ ]
- B. Have you any vision defect? ..... Yes No  
 If YES, state nature of defect \_\_\_\_\_ [ ] [ ]
- C. Have you any hearing defect? ..... Yes No  
 If YES, state nature of defect \_\_\_\_\_ [ ] [ ]
- D. 1) Have you had any breathing problems during normal activities? ..... Yes No  
 If YES, describe the problem \_\_\_\_\_ [ ] [ ]

- |  | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| 2) Have you had any past problems with respirator use? .....   | [ ]        | [ ]       |
| 3) Do you have claustrophobia? .....   | [ ]        | [ ]       |
| 4) Do you have facial hair or a facial deformity that might<br>interfere with a respirator fitting properly against your face? ..... | [ ]        | [ ]       |
| 5) Do you have any health problems when your body gets overheated?   | [ ]        | [ ]       |
| 6) Do you have chest pain or chest tightness when you exercise?<br>If YES, please describe _____                                     | [ ]        | [ ]       |

E. Are you suffering now or have you ever suffered from:

- |   | <u>Yes</u> | <u>No</u> |
|---|------------|-----------|
| 1) Epilepsy (or fits, seizures, convulsions)? ..... | [ ]        | [ ]       |
| 2) Rheumatic fever? .....                           | [ ]        | [ ]       |
| 3) Kidney disease? .....                            | [ ]        | [ ]       |
| 4) Bladder disease? .....                           | [ ]        | [ ]       |
| 5) Diabetes? .....                                  | [ ]        | [ ]       |
| 6) Palpitations or cardiac arrhythmias? .....       | [ ]        | [ ]       |
| 7) Jaundice? .....                                  | [ ]        | [ ]       |

F. Are you taking any medication? ..... [ ] [ ]  
If YES, please list \_\_\_\_\_

### CHEST COLDS AND CHEST ILLNESS

18. If you get a cold, does it usually go to your chest?  
(Usually means more than 1/2 the time)      a. Yes \_\_\_      b. No \_\_\_  
c. Don't get colds \_\_\_
19. A. During the past 3 years, have you had any chest  
illness that has kept you off work, indoors at  
home, or in bed?      a. Yes \_\_\_      b. No \_\_\_  
**IF NO TO 19A, GO TO QUESTION 20**  
**IF YES TO 19A:**
- B. Did you produce phlegm with any chest  
illness?      a. Yes \_\_\_      b. No \_\_\_
- C. In the past 3 years, how many episodes of illness with  
(increased) phlegm did you have that lasted a week  
or more?      a. If Yes, give # \_\_\_  
b. No such illness \_\_\_

- |   | <u>Yes</u>            | <u>No</u> |
|---|-----------------------|-----------|
| 20. Did you have any lung problems before the age of 16?                            | [ ]                   | [ ]       |
| 21. Have you ever had any of the following:   |                       |           |
| A. Attacks of bronchitis?   | [ ]                   | [ ]       |
| <b>IF YES TO A:</b>   |                       |           |
| 1) Was it confirmed by a doctor?  | [ ]                   | [ ]       |
| 2) At what age was your first attack?   | Age in years _____    |           |
|   | Do not remember _____ |           |
| B. Pneumonia (include bronchopneumonia)?  | [ ]                   | [ ]       |
| <b>IF YES TO B:</b>   |                       |           |
| 1) Was it confirmed by a doctor?  | [ ]                   | [ ]       |
| 2) At what age did you first have it?   | Age in years _____    |           |
|   | Do not remember _____ |           |
| C. Hay fever?   | [ ]                   | [ ]       |
| <b>IF YES TO C:</b>   |                       |           |
| 1) Was it confirmed by a doctor?  | [ ]                   | [ ]       |
| 2) At what age did it start?  | Age in years _____    |           |
|   | Do not remember _____ |           |
| 22. A. Have you ever had chronic bronchitis?<br>(bronchitis for more than 3 months) | [ ]                   | [ ]       |
| <b>IF YES TO 22A:</b>   |                       |           |
| B. Do you still have it?  | [ ]                   | [ ]       |
| C. Was it confirmed by a doctor?  | [ ]                   | [ ]       |
| D. At what age did it start?  | Age in years _____    |           |
|   | Do not remember _____ |           |
| 23. A. Have you ever been told by a doctor that<br>you had emphysema?               | [ ]                   | [ ]       |
| <b>IF YES TO 23A:</b>   |                       |           |
| B. Do you still have it?  | [ ]                   | [ ]       |
| C. Was it confirmed by a doctor?  | [ ]                   | [ ]       |
| D. At what age did it start?  | Age in years _____    |           |
|   | Do not remember _____ |           |

- |  |                    |                       |
|--|--------------------|-----------------------|
|  | <u>Yes</u>         | <u>No</u>             |
| 24. A. Have you ever had asthma?   | [ ]                | [ ]                   |
| <b>IF YES TO 24A:</b>  |                    |                       |
| B. Do you still have it?   | [ ]                | [ ]                   |
| C. Was it confirmed by a doctor?   | [ ]                | [ ]                   |
| D. At what age did it start?   | Age in years _____ | Do not remember _____ |
| E. If you no longer have it, at what age did it stop?                                | Age stopped _____  | Do not remember _____ |
| 25. Have you ever:   |                    |                       |
|  | <u>Yes</u>         | <u>No</u>             |
| A. had another chest illness?  | [ ]                | [ ]                   |
| If yes, please specify _____   |                    |                       |
| B. had chest pain?   | [ ]                | [ ]                   |
| If yes, please specify _____   |                    |                       |
| C. coughed up blood?   | [ ]                | [ ]                   |
| If yes, please specify _____   |                    |                       |
| D. had any chest operations?   | [ ]                | [ ]                   |
| If yes, please specify _____   |                    |                       |
| E. had any chest injuries?   | [ ]                | [ ]                   |
| If yes, please specify _____   |                    |                       |
| 26. A. Has a doctor ever told you that you have or currently have had heart trouble? |                    |                       |
|  | [ ]                | [ ]                   |
| <b>IF YES TO 26A ANSWER 26B-D</b>  |                    |                       |
| <b>IF NO TO 26A GO TO QUESTION 27</b>  |                    |                       |
| B. Have you ever received treatment for heart trouble in the past 10 years?          | [ ]                | [ ]                   |
| C. Have you ever had a heart attack?   | [ ]                | [ ]                   |
| D. Have you ever had angina?   | [ ]                | [ ]                   |
| 27. A. Has a doctor ever told you that you had high blood pressure?                  |                    |                       |
|  | [ ]                | [ ]                   |
| <b>IF YES TO 27A</b>   |                    |                       |

27. B. Have you had any treatment for high blood pressure (hypertension) in the past 10 years? Yes No  
   
Does not apply

28. When and where did you last have your chest X-rayed?

- A. 1. Approximate year \_\_\_\_\_  
 2. Doctor \_\_\_\_\_  
 3. Hospital \_\_\_\_\_  
 4. City and State \_\_\_\_\_  
 5. I do not remember \_\_\_\_\_

- B. 1. What was the outcome? \_\_\_\_\_  
 2. I do not know

29. Prior to chest X-ray listed above, when and where you have had a chest Xray in the past 10 years?

Approximate Year	Doctor	Hospital or Clinic	City	State
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____



**FAMILY HISTORY**

30. Were either of your natural parents ever told by a doctor that they had any of the following chronic lung conditions?

	<u>FATHER</u>			<u>MOTHER</u>		
	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>
A. Chronic Bronchitis?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
B. Emphysema?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
C. Asthma?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
D. Lung Cancer?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E. Other chest conditions?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
F. Is parent living?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
H. Please specify:	Age if living	_____		Age if living	_____	
	Age at death	_____		Age at death	_____	
	Don't know	_____		Don't know	_____	

G. Please state cause of death (if applicable)

1. Father \_\_\_\_\_

2. Mother \_\_\_\_\_

**COUGH**

	<u>Yes</u>	<u>No</u>
31. A. Do you usually have a cough? (Count a cough with first smoke or on first going outdoors. Exclude clearing of throat) If no, go to 32C.	[ ]	[ ]
B. Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week?	[ ]	[ ]
C. Do you usually cough at all on getting up or first thing in the morning?	[ ]	[ ]
D. Do you usually cough at all during the rest of the day or at night?	[ ]	[ ]

**IF YES TO ANY PART OF QUESTION 31 (A, B, C, or D), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK DOES NOT APPLY AND GO TO 32A.**

	<u>Yes</u>	<u>No</u>
E. Do you usually cough like this on most days for 3 consecutive months or more during the year? <b>Does not apply</b> _____	[ ]	[ ]

F. For how many years have you had the cough? <b>Does not apply</b> _____	Number of years _____
--	-----------------------

	<u>Yes</u>	<u>No</u>
32. A. Do you usually bring up phlegm from your chest? (Count phlegm with the first smoke or on first going outdoors. Exclude phlegm from the nose. Count swallowed phlegm) <b>If no, go to 32C.</b>	[ ]	[ ]

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

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

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

**IF NO TO ALL, GO TO 33A.**

**IF YES TO ANY PART OF QUESTION 32 (A, B, C, D), ANSWER THE FOLLOWING:**

	<u>Yes</u>	<u>No</u>
E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?	[ ]	[ ]

F. For how many years have you had trouble with phlegm?	Number of years _____
---	-----------------------

**EPISODES OF COUGH AND PHLEGM**

	<u>Yes</u>	<u>No</u>
33. A. 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)	[ ]	[ ]

**IF YES TO 33A.**

B. How long have you had one such episode?	Number of years _____
--	-----------------------

**WHEEZING**

34. A. Does your chest ever sound wheezy or whistling? Yes  
[ ] No  
[ ]

**IF YES TO 34A.**

- 1. When you have a cold? [ ] [ ]
- 2. Occasionally apart from colds? [ ] [ ]
- 3. Most days or nights? [ ] [ ]

**IF YES TO 1, 2, OR 3 ABOVE**

B. For how many years has this been present? Number of years \_\_\_\_\_

35. A. Have you ever had an attack of wheezing that has made you feel short of breath? Yes  
[ ] No  
[ ]

**IF YES TO 35A.**

B. How old were you when you first had such an attack? Age \_\_\_\_\_  
N/A \_\_\_\_\_

C. Have you had 2 or more such episodes? Yes  
[ ] No  
[ ]

D. Have you ever required medicine or treatment for an attack? [ ] [ ]

**BREATHLESSNESS**

36. A. If unable to walk due to a condition other than heart or lung disease, please describe and proceed to question 38.

Nature of condition(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? Yes  
[ ] No  
[ ]

**CHEST PAIN**

- |  |            |           |
|--|------------|-----------|
|  | <b>Yes</b> | <b>No</b> |
| 37. A. Have you had chest pain in the past year? | [ ]        | [ ]       |

If yes, when and under what circumstances? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IF YES TO 37A.**

- |  |            |           |
|--|------------|-----------|
|  | <b>Yes</b> | <b>No</b> |
| B. Do you have to walk slower than other people of your age on level ground because of breathlessness?         | [ ]        | [ ]       |
| C. Do you ever have to stop for breath when walking at your own pace on level ground?                          | [ ]        | [ ]       |
| D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on level ground? | [ ]        | [ ]       |
| E. Are you too breathless to leave the house or breathless after dressing or climbing one flight of stairs?    | [ ]        | [ ]       |
| 38. Have you coughed up blood recently?  | [ ]        | [ ]       |

If yes, when and under what circumstances? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |                                    |            |           |
|------------------------------------|------------|-----------|
|                                    | <b>Yes</b> | <b>No</b> |
| 39. Have you ever had lung cancer? | [ ]        | [ ]       |

**TOBACCO SMOKING**

- |   |            |                                  |
|---|------------|----------------------------------|
|   | <b>Yes</b> | <b>No</b>                        |
| 40. A. Have you ever smoked cigarettes?<br>(No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime, or less than 1 cigarette a day for a year). | [ ]        | [ ]                              |
| B. Do you now smoke cigarettes (as of one month ago)?   | [ ]        | [ ]                              |
| C. How old were you when you first started regular cigarette smoking?   |            | Age _____                        |
| D. If you have stopped smoking cigarettes completely, how old were you when you stopped?  |            | Age _____<br>Still smoking _____ |

E. How many cigarettes do you smoke per day now? Cigarettes/day \_\_\_\_\_  
Does not apply \_\_\_\_\_

F. On the average, of the entire time you smoked, how many cigarettes Cigarettes/day \_\_\_\_\_

G. Do, or did you, inhale the cigarette smoke? Yes No  
[ ] [ ]

**IF YES TO 40G**

At what level do you or did you inhale? Does not apply [ ]  
Not at all [ ]  
Slightly [ ]  
Moderately [ ]  
Deeply [ ]

41. A. Have you ever smoked a pipe regularly? Yes No  
(Yes means more than 12 oz. of tobacco in a lifetime). [ ] [ ]

**IF YES TO 41A.**

B. 1. How old were you when you started to smoke a pipe regularly? Age \_\_\_\_\_

2. If you have stopped smoking a pipe completely, how old were you when you stopped? Age \_\_\_\_\_  
Still Smoking \_\_\_\_\_  
Does not apply \_\_\_\_\_

C. On the average, over the entire time you smoked a pipe, \_\_\_\_\_ oz. per week  
how much pipe tobacco did you smoke per week? (standard pouch of tobacco  
contains 1 1/2 oz.)

D. How much pipe tobacco are you smoking now? \_\_\_\_\_ oz. per week  
\_\_\_\_\_ not currently smoking  
a pipe

E. Do you or did you inhale the pipe smoke? Never smoked [ ]  
At what level? Not at all [ ]  
Slightly [ ]  
Moderately [ ]  
Deeply [ ]

42. A. Have you ever smoked cigars regularly? Yes No  
(Yes means more than 1 cigar a week for a year) [ ] [ ]

**IF YES TO 42A.**

- B. 1. How old were you when you started smoking cigars regularly? Age \_\_\_\_\_
2. If you have stopped smoking cigars completely, how old were you when you stopped? Age \_\_\_\_\_  
 Still smoking cigars \_\_\_\_\_  
 Does not apply \_\_\_\_\_
- C. On the average, over the entire time you smoked cigars, how many cigars did you smoke per week? Cigars per week \_\_\_\_\_
- D. How many cigars are you smoking per week now? Cigars per week \_\_\_\_\_  
 Currently not smoking cigars \_\_\_\_\_
- E. Do you or did you inhale the cigar smoke? Never smoked [ ]  
 At what level? Not at all [ ]  
 Slightly [ ]  
 Moderately [ ]  
 Deeply [ ]

**GASTROINTESTINAL**

- |  | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| 43. Have you had unexplained weight loss?              | [ ]        | [ ]       |
| 44. Have you had rectal bleeding?                      | [ ]        | [ ]       |
| 45. Have you had black bowel movements?                | [ ]        | [ ]       |
| 46. Do you have a poor appetite?                       | [ ]        | [ ]       |
| 47. Have you had intestinal, stomach or rectal cancer? | [ ]        | [ ]       |

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_

The information you provided above will be kept confidential unless you desire that it be released. An employer cannot require that you sign a release of this questionnaire or any other medical information in order for you to obtain or keep a job. You have a right to have the physician keep the medical records.