

PART 2
PERIODIC MEDICAL QUESTIONNAIRE

1. NAME _____
2. SOCIAL SECURITY NUMBER _____
3. CLOCK OR BADGE NUMBER _____
4. PRESENT OCCUPATION _____
5. PLANT _____
6. ADDRESS _____
7. _____
(Zip Code)
8. TELEPHONE NUMBER _____
(Area Code)
9. INTERVIEWER _____
10. DATE _____

11. What is your marital status?

- Single _____
- Married _____
- Widowed _____
- Separated/ _____
- Divorced _____

12. OCCUPATIONAL HISTORY

12A. In the past year did you work full time (30 Hours per week or more) for six months or more?

Yes No

If Yes to 12A:

12B. In the past year, did you work in a dusty job?

Yes No Does not apply

12C. Was dust exposure:

Mild _____ Moderate _____ Severe _____

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

12E. Was exposure:

Mild _____ Moderate _____ 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?

Yes No

IF NO, STATE REASON:

13B. In the past year have you developed:

Yes No

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

14. CHEST COLDS AND CHEST ILLNESSES

14A. If you get a cold, does it usually go to your chest?
(Usually means more than half the time).

Yes No 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?

Yes _____ No _____ Does not apply _____

IF YES TO 15A:

15B. Did you produce phlegm with any of these chest illnesses?

Yes _____ No _____ 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 such 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
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Frequent Colds

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 _____

Signature _____ Date _____