ASBESTOS EXPOSURE
PART II - PERIODIC MEDICAL QUESTIONNAIRE

IDENTIFICATION

1. NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NO. *(1 - 9)*	3. CLOCK NO. *(10 - 15)*	4. PRESENT OCCUPATION

5. NAME OF PLANT	6. STREET ADDRESS OF PLANT	7. PLANT CITY, STATE AND ZIP CODE

8. TELEPHONE NO. *(Include area code)*	9. NAME OF INTERVIEWER	10. DATE OF INTERVIEW *(16 - 21) (YYYYMMDD)*	11. MARITAL STATUS *(X one)*
			☐ a. SINGLE ☐ b. MARRIED ☐ c. WIDOWED ☐ d. DIVORCED/SEPARATED

MEDICAL DATA

12. OCCUPATIONAL HISTORY	Yes	No	N/A
a. IN THE PAST YEAR, DID YOU WORK FULL TIME *(30 hours per week or more)* FOR SIX MONTHS OR MORE?	☐	☐	
b. DID YOU WORK AT ANY DUSTY JOB DURING THE PAST YEAR? * *If Yes, complete c.*	☐	☐	
c. WAS EXPOSURE *(X one)* ☐ MILD ☐ MODERATE ☐ SEVERE			☐
d. IN THE PAST YEAR, WERE YOU EXPOSED TO GAS OR CHEMICAL FUMES IN YOUR WORK? **If Yes, complete e.*	☐	☐	
e. WAS EXPOSURE *(X one)* ☐ MILD ☐ MODERATE ☐ SEVERE			☐
f. IN THE PAST YEAR, WHAT WAS YOUR			
(1) Job/Occupation			
(2) Position/Job Title			

13. MEDICAL HISTORY	Yes	No	N/A
a. DO YOU CONSIDER YOURSELF TO BE IN GOOD HEALTH? **If No, state reason.*	☐	☐	
b. IN THE PAST YEAR, HAVE YOU DEVELOPED			
(1) Epilepsy *(Or fits, seizures or convulsions)*	☐	☐	
(2) Rheumatic Fever	☐	☐	
(3) Kidney Disease	☐	☐	
(4) Bladder Disease	☐	☐	
(5) Diabetes	☐	☐	
(6) Jaundice	☐	☐	
14. IF YOU GET A COLD, DOES IT USUALLY GO TO YOUR CHEST? *(Usually means more than 1/2 of the time)*Don't get colds*	☐	☐	☐
15. CHEST ILLNESSES			
a. DURING THE PAST YEAR, HAVE YOU HAD ANY CHEST ILLNESSES THAT HAVE KEPT YOU OFF WORK, INDOORS AT HOME, OR IN BED?	☐	☐	
b. IF YES, DID YOU PRODUCE PHLEGM WITH ANY OF THESE ILLNESSES?	☐	☐	☐
c. IN THE LAST YEAR, HOW MANY SUCH ILLNESSES WITH INCREASED PHLEGM DID YOU HAVE WHICH LASTED A WEEK OR MORE? *(List number)*			

16. RESPIRATORY SYSTEM

a. IN THE PAST YEAR, HAVE YOU HAD	* Yes	No	b. DO YOU HAVE		
			(1) Frequent Colds	☐	☐
(1) Asthma	☐	☐	(2) Chronic Cough	☐	☐
(2) Bronchitis	☐	☐	(3) Shortness of breath when walking or climbing one flight of stairs	☐	☐
(3) Hay Fever	☐	☐			
(4) Other Allergies	☐	☐	c. DO YOU		
(5) Pneumonia	☐	☐	(1) Wheeze	☐	☐
(6) Tuberculosis	☐	☐	(2) Cough up phlegm	☐	☐
(7) Chest Surgery	☐	☐	(3) Smoke cigarettes *(If yes:)*	☐	☐
(8) Other Lung Problems	☐	☐	Packs per day		
(9) Heart Disease	☐	☐	Number of years		

17. REMARKS *(*Use this section to further comment on positive answers)*

18. SIGNATURE	19. DATE SIGNED *(YYYYMMDD)*