



**APPENDIX D  
FEDERAL REGISTER 1910.1001  
MEDICAL QUESTIONNAIRE MANDATORY**

**INITIAL ASBESTOS MEDICAL QUESTIONNAIRE**

1. Name \_\_\_\_\_
2. Social Security Number \_\_\_\_\_
3. Clock Number \_\_\_\_\_
4. Present Occupation \_\_\_\_\_
5. Plant \_\_\_\_\_
6. Address \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_
7. Telephone Number \_\_\_\_\_
8. Interviewer \_\_\_\_\_
9. Date \_\_\_\_\_
10. Date of Birth \_\_\_\_\_
11. Place of Birth \_\_\_\_\_
12. Sex - Male  Female
13. What is your marital status? Single  Separated  Married  Divorced  Widowed
14. Race - White  Hispanic  Black  Indian  Asian  Other
15. What is the highest grade completed in school? \_\_\_\_\_  
(For example – 12 years is completion of high school)

**OCCUPATIONAL HISTORY**

16A. Have you ever worked full time (30 hours per week or more) for 6 months or more? Yes  No

IF YES TO 16A:

16B. Have you ever worked for a year or more in any dusty job? Yes  No   
Does Not Apply

Specific job/industry \_\_\_\_\_ Total Years Worked \_\_\_\_\_

Was dust exposure: Mild  Moderate  Severe

16C. Have you ever been exposed to gas or chemical fumes in your work? Yes  No

Specific job/industry \_\_\_\_\_ Total Years Worked \_\_\_\_\_

Was exposure: Mild  Moderate  Severe

16D. 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 \_\_\_\_\_

(Record on lines the years in which you have worked in any of these industries, e.g. 1960-1969)

Have you ever worked: Yes No

16E. In a mine?

16F. In a quarry?

16G. In a foundry?

16H. In a pottery?

16I. In a cotton, flax, or hemp mill?

16J. With asbestos?

**PAST MEDICAL HISTORY**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 17A. Do you consider yourself to be in good health?         | <input type="checkbox"/> | <input type="checkbox"/> |
| If no, state reason _____                                   |                          |                          |
| 17B. Have you any defect of vision?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, state reason _____                                  |                          |                          |
| 17C. Have you any hearing defect?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, state reason _____                                  |                          |                          |
| 17D. Are you suffering from or have you ever suffered from: | Yes                      | No                       |
| a. Epilepsy (or fits, seizures, convulsions)?               | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Rheumatic fever?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Kidney disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Bladder disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Diabetes?  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Jaundice?  | <input type="checkbox"/> | <input type="checkbox"/> |

**CHEST COLDS AND CHEST ILLNESSES**

- |  |  |                             |
|--|--|-----------------------------|
| 18. If you get a cold, does it <u>usually</u> go to your chest?<br>(Usually means more than 1/2 the time)                | Yes <input type="checkbox"/>               | No <input type="checkbox"/> |
|  | Don't get colds <input type="checkbox"/>   |                             |
| 19A. During the past 3 years, have you had any chest illness<br>that have kept you off work, indoors at home, or in bed? | Yes <input type="checkbox"/>               | No <input type="checkbox"/> |
| IF YES TO 19A:   |  |                             |
| 19B. Did you produce phlegm with any of these chest illnesses?   | Yes <input type="checkbox"/>               | No <input type="checkbox"/> |
|  | Does not apply <input type="checkbox"/>    |                             |
| 19C. In the last 3 years, how many such illnesses with<br>(increased) phlegm did you have which lasted a week or more?   | Number of illnesses _____                  |                             |
|  | No such illnesses <input type="checkbox"/> |                             |
| 20. Did you have any lung trouble before the age of 16?  | Yes <input type="checkbox"/>               | No <input type="checkbox"/> |

21. Have you ever had any of the following?

1A. Attacks of bronchitis? Yes  No

IF YES TO 1A:

1B. Was it confirmed by a doctor? Yes  No   
Does not apply

1C. At what age was your first attack? Age in year's \_\_\_\_\_  
Does not apply

2A. Pneumonia (include bronchopneumonia)? Yes  No

IF YES TO 2A:

2B. Was it confirmed by a doctor? Yes  No   
Does not apply

2C. At what age did you first have it? Age in year's \_\_\_\_\_  
Does not apply

3A. Hay Fever? Yes  No

IF YES TO 3A:

3B. Was it confirmed by a doctor? Yes  No   
Does not apply

3C. At what age did it start? Age in year's \_\_\_\_\_  
Does not apply

22. Have you ever had chronic bronchitis? Yes  No

IF YES TO 22:

1A. Do you still have it? Yes  No   
Does not apply

1B. Was it confirmed by a doctor? Yes  No   
Does not apply

1C. At what age did it start? Age in year's \_\_\_\_\_  
Does not apply

23. Have you ever had emphysema? Yes  No

IF YES TO 23:

1A. Do you still have it? Yes  No   
Does not apply

1B. Was it confirmed by a doctor? Yes  No   
Does not apply

1C. At what age did it start? Age in year's \_\_\_\_\_  
Does not apply

24. Have you ever had asthma? Yes  No

IF YES TO 24:

1A. Do you still have it? Yes  No   
Does not apply

1B. Was it confirmed by a doctor? Yes  No   
Does not apply

1C. At what age did it start? Age in year's \_\_\_\_\_  
Does not apply

1D. If you no longer have it, at what age did it stop? Age stopped \_\_\_\_\_

25. Have you ever had:

1A. Any other chest illness? Yes  No

If yes, please specify \_\_\_\_\_

1B. Any chest operations? Yes  No

If yes, please specify \_\_\_\_\_

1C. Any chest injuries? Yes  No

If yes, please specify \_\_\_\_\_

26. Has a doctor ever told you that you had heart trouble? Yes  No

IF YES TO 26

1A. Have you ever had treatment for heart trouble in the  
the past 10 years? Yes  No   
Does not apply

27. Has a doctor ever told you that you had high blood pressure? Yes  No

IF YES TO 27:

1A. Have you had any treatment for high blood pressure (hypertension) in the past 10 years? Yes  No   
Does not apply

28. When did you last have your chest x-rayed? Year \_\_\_\_\_

29. Where did you last have your chest x-rayed (if known)? \_\_\_\_\_

What was the outcome? \_\_\_\_\_

**FAMILY HISTORY**

30. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

	<u>FATHER</u>			<u>MOTHER</u>		
	Yes	No	Don't Know	Yes	No	Don't Know
A. Chronic bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Lung Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Other chest conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Is parent currently alive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Please specify:	_____Age if Living			_____Age if Living		
	_____Age at Death			_____Age at Death		
	_____Don't Know			_____Don't Know		
H. Please specify cause of death, if applicable						
	Father _____			Mother _____		

**COUGH**

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

IF YES TO ANY OF THE ABOVE (31A, B, C, OR D), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK DOES NOT APPLY AND SKIP TO 33A.

- 31E. Do you usually cough like this on most days for 3 consecutive months or more during the year? Yes  No   
Does not apply
- 31F. For how many years have you had the cough? Number of year's   
Does not apply
- 32A. Do you usually bring up phlegm from your chest? (Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) (If no, skip to 32C.) Yes  No
- 32B. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week? Yes  No
- 32C. Do you usually bring up phlegm at all on getting up or first thing in the morning? Yes  No
- 32D. Do you usually bring up phlegm at all during the rest of the day or at night? Yes  No

IF YES TO ANY OF THE ABOVE (32A, B, C, OR D), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK DOES NOT APPLY AND SKIP TO 33A.

- 32E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year? Yes  No   
Does not apply
- 32F. For how many years have you had trouble with phlegm? Number of year's   
Does not apply

**EPISODES OF COUGH AND PHLEGM**

33A. 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) Yes  No

IF YES TO 33A:

33B. For how long have you had at least 1 such episode per year? Number of year's \_\_\_\_\_  
Does not apply

**WHEEZING**

34A. Does your chest ever sound wheezy or whistling?

1. When you have a cold? Yes  No

2. Occasionally apart from colds? Yes  No

3. Most days or nights? Yes  No

IF YES TO 1, 2, OR 3 IN 34A:

34B. For how many years has this been present? Number of year's \_\_\_\_\_  
Does not apply

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

IF YES TO 35A:

35B. How old were you when you had your first such attack? Age in year's \_\_\_\_\_  
Does not apply

35C. Have you had 2 or more such episodes? Yes  No   
Does not apply

35D. Have you ever required medicine or treatment for the(se) attack(s)? Yes  No   
Does not apply

**BREATHLESSNESS**

36. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to 38A.

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

37A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill? Yes  No

IF YES TO 37A:

37B. Do you have to walk slower than people of your age on the level because of breathlessness? Yes  No   
Does not apply

37C. Do you ever have to stop for breath when walking at your own pace on the level? Yes  No   
Does not apply

37D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level? Yes  No   
Does not apply

37E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs? Yes  No   
Does not apply

**TOBACCO SMOKING**

38A. Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or 12 oz of tobacco in a lifetime or less than 1 cigarette a day for 1 year.) Yes  No

IF YES TO 38A:

38B. Do you now smoke cigarettes (as of one month ago?) Yes  No   
Does not apply

38C. How old were you when you first started regular cigarette smoking? Age in year's \_\_\_\_\_  
Does not apply

38D. If you have stopped smoking cigarettes completely, how old were you when you stopped? Age stopped \_\_\_\_\_  
Still smoking   
Does not apply

38E. How many cigarettes do you smoke per day now? Cigarettes per day \_\_\_\_\_  
Does not apply

38F. On the average of the entire time you smoked, how many cigarettes did you smoke per day? Cigarettes per day \_\_\_\_\_  
Does not apply

38G. Do or did you inhale the cigarette smoke: Does not apply  Not at all  Slightly  Moderately  Deeply

39A. Have you ever smoked a pipe regularly? (Yes, means more than 12 oz of tobacco in a lifetime.) Yes  No

IF YES TO 39A:

**FOR PERSONS WHO HAVE EVER SMOKED A PIPE**

- 39B. 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 stopped \_\_\_\_\_  
Still smoking pipe   
Does not apply
- 39C. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week?  
(A standard pouch of tobacco contains 1 ½ oz) \_\_\_\_\_oz per week  
Does not apply
- 39D. How much pipe tobacco are you smoking now? \_\_\_\_\_oz per week  
Not currently smoking a pipe
- 39E. Do you or did you inhale the pipe smoke?  
Never smoked  Not at all  Slightly  Moderately  Deeply
- 40A. Have you ever smoked cigars regularly? Yes  No   
(Yes, means more than 1 cigar a week for a year)

IF YES TO 40A:

**FOR PERSONS WHO HAVE EVER SMOKED CIGARS**

- 40B. 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 stopped \_\_\_\_\_  
Still smoking cigars   
Does not apply
- 40C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week? Cigars per week \_\_\_\_\_  
Does not apply
- 40D. How many cigars are you smoking per week now? Cigars per week \_\_\_\_\_  
Not currently smoking cigars
- 40E. Do you or did you inhale the cigar smoke?  
Never smoked  Not at all  Slightly  Moderately  Deeply

Signature \_\_\_\_\_ Date \_\_\_\_\_