



APPENDIX D
FEDERAL REGISTER 1910.1001
MEDICAL QUESTIONNAIRE MANDATORY

PERIODIC ASBESTOS MEDICAL QUESTIONNAIRE

- 1. Name:
2. Social Security#:
3. Date:
4. Present Occupation:
5. Company:
6. Address: Zip:
7. Telephone Number:
8. Doctor:
9. What is your marital status? Single Separated Married Divorced Widowed

OCCUPATIONAL HISTORY

- 10. In the past year, did you work full time (30 hours per week or more) for 6 months or more?
Yes No

If YES to 11:

- 11. In the past year, did you work in a dusty job? Yes No Does not apply
12. Was dust exposure: Mild Moderate Severe
13. In the past year, were you exposed to gas or chemical fumes in your work? Yes No
14. Was exposure: Mild Moderate Severe
15. In the past year, what was your:
1. Job/Occupation:
2. Position/Job Title:

RECENT MEDICAL HISTORY

- 16. Do you consider yourself to be in good health? Yes No
If no, state reason:
17. In the past year, have you developed?
Epilepsy Yes No
Rheumatic fever Yes No

	Yes	No
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Bladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>

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)
 Yes No Don't get colds
19. 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
20. Did you produce phlegm with any of these illnesses? Yes No Does not apply
21. 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 _____

RESPIRATORY SYSTEM

	Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Other Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>

Further Comment on Positive Answers: _____

Do you have:

- Frequent Colds Yes No
- Chronic Cough Yes No
- Shortness of breath when walking or climbing one flight of stairs? Yes No

Further Comment on Positive Answers: _____

Do you:

- | | Yes | No | |
|------------------|--------------------------|--------------------------|--|
| Wheeze | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cough up Phlegm | <input type="checkbox"/> | <input type="checkbox"/> | |
| Smoke Cigarettes | <input type="checkbox"/> | <input type="checkbox"/> | Pack(s) per day _____ How many years _____ |

Signature: _____ Date: _____