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**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?
(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
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
(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 _____