Industrial Medical Associates, P.C.

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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?

	Yes	No
Epilepsy	☐	☐
Rheumatic fever	☐	☐

	Yes	No
Kidney disease	☐	☐
Bladder disease	☐	☐
Diabetes	☐	☐
Jaundice	☐	☐
Cancer	☐	☐

CHEST COLDS AND CHEST ILLNESS

18. If you get a cold, does it usually go to your chest? (usually means more than ½ 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	☐	☐
Bronchitis	☐	☐
Hay Fever	☐	☐
Other Allergies	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Chest Surgery	☐	☐
Other Lung Problems	☐	☐
Heart Disease	☐	☐

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	☐	☐	
Cough up Phlegm	☐	☐	
Smoke Cigarettes	☐	☐	Pack(s) per day ______ How many years ______

Signature: ____ Date: ____________________