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	Yes*	No
			(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)*