Asbestos Annual Medical Questionnaire

335 N 120th Holland, MI 49424
Phone: (616)392-5222 Fax: (616) 392-3653

Name: _____ SSN: _____DOB:_____

Present Occupation: _____ Plant: _____

Address: _____ Phone: _____

OCCUPATIONAL HISTORY:

1. In the past year, did you work full time (30 hours per week or more) for 6 months or more? Yes_____ No_____

2. IF YES TO 1: A. In the past year, did you work in a dusty job? Yes_____ No_____

B. Was dust exposure: Mild_____ Moderate_____ Severe_____

3. C. In the past year, were you exposed to gas or chemical fumes in your work? Yes_____ No_____

D. Was exposure: Mild_____ Moderate_____ Severe_____

E. In the past year, what was your: Job/occupation? _____

Position/job title? _____

RECENT MEDICAL HISTORY

1. Do you consider yourself to be in good health? Yes_____ No_____

If "No", state reason _____

2. In the past year, have you developed:

Epilepsy? Yes_____ No_____ Rheumatic fever? Yes_____ No_____

Kidney disease? Yes_____ No_____ Bladder disease? Yes_____ No_____

Diabetes? Yes_____ No_____ Jaundice? Yes_____ No_____

Cancer? Yes_____ No_____

4. 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

_____

Don't get colds
_____

4. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? Yes_____ No_____

IF YES TO 4: A. Did you produce phlegm with any of these chest illnesses? Yes_____ No_____

B. In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more? Number of illnesses _____

5. In the past year have you had:

Asthma: Yes_____ No_____ Bronchitis: Yes_____ No_____
Hay Fever: Yes_____ No_____ Other Allergies: Yes_____ No_____
Pneumonia: Yes_____ No_____
Tuberculosis: Yes_____ No_____
Chest Surgery: Yes_____ No_____ Other Lung Problems: Yes_____ No_____
Heart Disease: Yes_____ No_____
If "Yes" to any of the above, please explain:_____

5. Do you have:

Frequent colds: Yes_____ No_____ Chronic cough: Yes_____ No_____
Wheezing: Yes_____ No_____ Coughing up phlegm: Yes_____ No_____
Shortness of Breath when walking 1 flight of stairs: Yes_____ No_____

7. Do you smoke cigarettes? Yes_____ No_____

I certify that I have answered truthfully questions regarding my health history and have not knowingly withheld any information concerning my health status or exposure to chemicals either past or present.

Patient Signature: _____ Date: _____