OSHA PERIODIC ASBESTOS MEDICAL QUESTIONNAIRE

1. NAME _____

2. SOCIAL SECURITY NUMBER # (last 4-digits) _____

3. CLOCK NUMBER FULL TIME ☐ PART TIME ☐

4. PRESENT OCCUPATION _____

5. PLANT / Department _____

6. ADDRESS _____

_____

_____

7. (City, ST Zip)

8. TELEPHONE NUMBER _____

9. INTERVIEWER _____

10. DATE _____

11. What is your marital status? Single ☐ Married ☐ Widowed ☐ Separated/ Divorced ☐

12. OCCUPATIONAL HISTORY

	Yes	No
12A. In the past year, did you work full time (30 hours per week or more) for 6 months or more?	☐	☐
IF YES TO 12A:		
12B. In the past year, did you work in a dusty job?	☐	☐
	Does Not Apply	☐
12C. Was dust exposure:	Mild	☐
	Moderate	☐
	Severe	☐
12D. In the past year, were you exposed to gas or chemical fumes in your work?	Yes	No
	☐	☐
12E. Was exposure:	Mild	☐
	Moderate	☐
	Severe	☐

12F. In the past year, what was your:

1. Job/occupation? _____

2. Position/job title? _____

13. RECENT MEDICAL HISTORY

	Yes	No
13A. Do you consider yourself to be in good health?	☐	☐
If NO, state reason		

13B. In the past year, have you developed:

	Yes	No
Epilepsy?	☐	☐
Rheumatic fever?	☐	☐
Kidney disease?	☐	☐
Bladder disease?	☐	☐
Diabetes?	☐	☐
Jaundice?	☐	☐
Cancer?	☐	☐

14. CHEST COLDS AND CHEST ILLNESSES

	Yes	No
14A. If you get a cold, does it "usually" go to your chest? (usually means more than 1/2 the time)	☐	☐
	Don't get colds	☐
15A. During the past year, have you had any chest illnesses that have kepty you off work, indoors at home, or in bed?	☐	☐
IF YES TO 15A:	Does Not Apply	☐
15B. Did you produce phlegm with any of these chest illnesses?	☐	☐
	Does Not Apply	☐
15C. 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	☐

16. RESPIRATORY SYSTEM

In the past year have you had:	Yes	No	Further Comment on Positive Answers
Asthma	☐	☐	
Bronchitis	☐	☐	

	Yes	No	Further Comment on Positive Answers
Hay Fever	☐	☐	
Other Allergies	☐	☐	
Pneumonia	☐	☐	
Tuberculosis	☐	☐	
Chest Surgery	☐	☐	
Other Lung Problems	☐	☐	
Heart Disease	☐	☐	
Do you have:			
Frequent colds	☐	☐	
Chronic cough	☐	☐	
Shortness of breath when walking or climbing one flight of stairs	☐	☐	
Do you:			
Wheeze	☐	☐	
Cough up phlegm	☐	☐	
Smoke cigarettes	☐	☐	
Packs per day			
How many years			

Signature _____ Date _____