

UNIVERSITY OF MARYLAND
UNIVERSITY HEALTH CENTER

Initial Asbestos Questionnaire

Name: _____ Social Security Number: _____ Date: _____
Home Address: _____ Dept: _____
Position: _____ Supervisor: _____ Home Phone: _____
Work Phone: _____ Work E-mail Address: _____ Date of birth: _____

Patient Information:

A) Are you currently being treated by a doctor for any illness or injury?
Yes No If yes please list: _____

B) Are you currently taking any prescriptions, non-prescriptions, or herbal medications?
Yes No If yes, list medicines: _____

C) If you have seen a doctor in the past 6 weeks, state why: _____

D) List any food, drug, or chemical allergies you have: _____

E) Place of birth: _____

F) Sex: Male Female Transgendered Other _____

G) Marital Status: Single Married Widowed Separated/Divorced

H) Race: White Black Asian Hispanic Indian Other

I) What is the highest grade completed in school? _____
(For example 12 years is completion of high school)

J) Are you in the Asbestos Program?
Yes No

K) Are you in the Voluntary Asbestos Program?
Yes No

L) Do you wear a respirator for any other purpose at work? Yes No
What kind? _____ and for what purpose? _____

Occupational History:

A) Have you ever worked full time (30 hours/week) for 6 months or more? Yes No

If yes to A:

B) Have you ever worked for a year or more in any dusty job? Yes No Doesn't apply
Specify job/industry _____ Total years worked _____
Was dust exposure: Mild Moderate Severe

C) Have you ever been exposed to gas or chemical fumes in your work? Yes No
Specify job/industry _____ Total years worked _____
Was exposure: Mild Moderate Severe

D) What has been your usual occupation or job -- the one you have worked at the longest?

1. Job occupation _____
2. Number of years employed at 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)

E) In the past year, what was your:

1. Job/occupation? _____
2. Position/job title? _____

Have you ever worked:

- | | | | | | |
|------------------|------------------------------|-----------------------------|------------------------------------|------------------------------|-----------------------------|
| F) In a mine? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | I) In a pottery? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| G) In a quarry? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | J) In a cotton, flax or hemp mill? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| H) In a foundry? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | K) With asbestos? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Past Medical History:

- A) Do you consider yourself to be in good health? Yes No
If no state reason _____
- B) Have you any defect of vision? Yes No
If yes state nature of defect _____
- C) Have you any hearing defect? Yes No
If yes state nature of defect _____
- D) Are you suffering from or have you ever suffered from:
1. Epilepsy (or fits, seizures, convulsions)? Yes No
 2. Rheumatic fever? Yes No
 3. Kidney disease? Yes No
 4. Bladder disease? Yes No
 5. Diabetes? Yes No

Chest Colds and Chest Illnesses:

1. If you get a cold, does it "usually" go to your chest? Yes No Don't get colds
(Usually means more than 1/2 the time)
- 2 A) During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? Yes No
- If yes to 2A:
- B) Did you produce phlegm with any of these chest illnesses? Yes No Doesn't apply
- C) 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 _____
3. Did you have any lung trouble before the age of 16? Yes No
4. Have you ever had any of the following?
- A) Attacks of bronchitis? Yes No

If yes to 4A:

1) Was it confirmed by a doctor?

Yes No Doesn't apply

2) At what age was your first attack?

Age in years _____ Doesn't apply _____

B) Pneumonia (include bronchopneumonia)?

Yes No

If yes to 4B:

1) Was it confirmed by a doctor?

Yes No Doesn't apply

2) At what age did you first have it?

Age in years _____ Doesn't apply _____

C) Hay Fever?

Yes No

If yes to 4C:

1) Was it confirmed by a doctor?

Yes No Doesn't apply

2) At what age did it start?

Age in years _____ Doesn't apply _____

5 A) Have you ever had chronic bronchitis?

Yes No

If yes to 5A:

B) Do you still have it?

Yes No Doesn't apply

C) Was it confirmed by a doctor?

Yes No Doesn't apply

D) At what age did it start?

Age in years _____ Doesn't apply _____

6. Have you ever had emphysema?

Yes No

If yes to 6:

A) Do you still have it?

Yes No Doesn't apply

B) Was it confirmed by a doctor?

Yes No Doesn't apply

C) At what age did it start?

Age in years _____ Doesn't apply _____

7. Have you ever had asthma?

Yes No

If yes to 7:

1) Do you still have it?

Yes No Doesn't apply

2) Was it confirmed by a doctor?

Yes No Doesn't apply

3) At what age did it start?

Age in years _____ Doesn't apply _____

4) If you no longer have it, at what age did it stop? Age stopped _____ Doesn't apply _____

8. Have you ever had:

A) Any other chest illness?

Yes No

If yes, please specify _____

B) Any chest operations?

Yes No

If yes, please specify _____

C) Any chest injuries?

Yes No

If yes, please specify _____

9. Has a doctor ever told you that you had heart trouble? Yes No

If yes to 9:

A) Have you had any treatment for heart trouble in the past 10 years?

Yes No Doesn't apply

10. Has a doctor told you that you had high blood pressure? Yes No

If yes to 10:

B) Have you had any treatment for high blood pressure (hypertension) in the past 10 years?

Yes No Doesn't apply

11. When did you last have you chest X-rayed? Year_____

12. Where did you last have your chest X-rayed (if known)?

What was the outcome? _____

Family History:

1. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

	Father			Mother		
	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	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

H) Please specify cause of death _____

Cough:

1 A) Do you usually have a cough? (Count a cough with first smoke or first going out of doors. Exclude clearing of throat.) Yes No

If no, skip to question 1C

B) Do you usually cough as much as 4 to 6 times a day or more days out of the week? Yes No

- C) Do you usually cough at all on getting up or first thing in the morning? Yes No
- D) Do you usually cough at all during the rest of the day or at night? Yes No

IF YES TO ANY OF THE ABOVE (1 A, B, C, D), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK DOESN'T APPLY AND SKIP TO WHEEZING #1.

- E) Do you usually cough like this on most days for 3 consecutive months or more during the year? Yes No Doesn't apply
- F) For how many years have you had the cough? Number of years _____ Doesn't apply _____

2. 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.) Yes No

If no, skip to 2B

- A) Do you usually bring up phlegm like this as much as twice a day or 4 or more days out of the week? Yes No
- B) Do you usually bring up phlegm at all on getting up or first thing in the morning? Yes No
- C) 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 (2, A, B, ORC), answer the following. If NO to all, check doesn't apply and skip to 1A.

- D) Do you bring up phlegm like this on most days for 3 consecutive months or more during the year? Yes No Doesn't apply
- E) For how many years have you had trouble with phlegm? Number of years _____ Doesn't apply _____

Episodes of cough and phlegm:

1. Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year? Yes No
- *For persons who usually have cough and/or phlegm

If yes to 1:

- A) For how long have you had at least one such episode per year? Number of years _____ Doesn't apply _____

Wheezing:

1. Does your chest ever sound wheezy or whistling?

A) When you have a cold?

Yes No

B) Occasionally apart from colds?

Yes No

C) Most days or nights?

Yes No

If yes to A, B or C:

D) For how many years has this been present?

Number of years _____ Doesn't apply _____

2. Have you ever had an attack of wheezing that has made you feel short of breath?

Yes No Doesn't apply

If yes to 2:

A) How old were you when you had your first such attack?

Age in years _____ Doesn't apply _____

B) Have you had 2 or more such episodes?

Yes No Doesn't apply

C) Have you ever required medicine or treatment for the(se) attack(s)?

Yes No Doesn't apply

Breathlessness:

1. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to Tobacco Smoking #1.

Nature of condition(s) _____

2. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

Yes No

If yes to 2:

A) Do you ever walk slower than people of your age on the level because of breathlessness?

Yes No Doesn't apply

B) Do you ever stop for breath when walking at your own pace on the level?

Yes No Doesn't apply

C) Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?

Yes No Doesn't apply

D) Are you too breathless to leave the house or breathless on dressing or climbing

Yes No Doesn't apply

Tobacco Smoking:

1 A) Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than one cigarette a day for one year)

Yes No

If yes to 1A:

B) Do you now smoke cigarettes?
(as of one month ago)

Yes No Doesn't apply

C) How old were you when you first started regular cigarette smoking?

Age in years _____ Doesn't apply _____

D) If you have stopped smoking cigarettes completely, how old were you when you stopped?

Age if stopped _____ Still smoking
Doesn't apply

E) How many cigarettes do you smoke per day now?

Cigarettes a day _____ Doesn't apply _____

F) On the average of the entire time smoked, how many cigarettes did you smoke per day?

Cigarettes a day _____ Doesn't apply _____

G) Do or did you inhale the cigarette smoke?

Doesn't apply Not at all
Slightly Moderately Deeply

2 A) Have you ever smoked a pipe regularly? (Yes means more than 12 oz. of tobacco in a lifetime)

Yes No

If yes to 2A:

B) 1. How old were you when you started to smoke a pipe regularly?

Age _____

2. If you have stopped smoking a pipe regularly, how old were you when you stopped?

Age if stopped _____ Still smoking
Doesn't apply

C) On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week?

_____ oz. per week (a standard pouch of tobacco contains 1 1/2 oz.)
Doesn't apply

D) How much pipe tobacco are you smoking now?

_____ oz. per week
Not currently smoking a pipe

E) Do you or did you inhale the pipe smoke?

Never smoked Not at all
Slightly Moderately Deeply

3 A) Have you ever smoked cigars regularly? (Yes means more than 1 cigar a week for a year)

Yes No

If yes to 3A: **FOR PERSONS WHO HAVE SMOKED A PIPE**

B) 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
Doesn't apply

C) On the average over the entire time you smoked cigars, how many cigars did you smoke per week?

Cigars per week _____ Doesn't apply

D) How many cigars are you smoking per week now?

Cigars per week _____
Not currently smoking cigars

E) Do or did you inhale the cigar smoke?

Never smoked Not at all
Slightly Moderately Deeply

I understand that this physical examination is not designed, nor intended, to replace a regular physical examination, or routine medical care, by my private physician. I understand that this examination and all subsequent examinations are highly specific to evaluate my ability to perform certain tasks noted in my job description. This examination will not cover all aspects of a full physical examination.

Signature _____ Date _____