University of Maryland
University Health Center

Periodic Asbestos Questionnaire

Name: _____ UID: _____ 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. Marital Status: Single ☐ Married ☐ Widowed ☐ Separated/Divorced ☐
F. Are you in the Asbestos Program? Yes ☐ No ☐
G. Are you in the Voluntary Asbestos Program? Yes ☐ No ☐
H. Do you wear a respirator for any purpose at work? Yes ☐ No ☐
   What kind? _____ and for what purpose? _____

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 ☐ If yes, please list: _____
   A. In the past year, did you work in a dusty job? Yes ☐ No ☐ Doesn't apply ☐
   B. Was dust exposure: Mild ☐ Moderate ☐ Severe ☐
   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:
      1. Job/occupation? _____
      2. 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 ☐			

Chest colds and chest illnesses:

1. If you get a cold, does it "usually" go to your chest? (usually means more than 1/2 the time)
   Yes ☐ No ☐ Don't get colds ☐
2. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? Yes ☐ No ☐ Doesn't apply ☐
   If yes to 2:
   A. Did you produce phlegm with any of these chest illnesses? Yes ☐ No ☐ Doesn't apply ☐

B. 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:

In the past year, have you had:			Further comment if answered yes
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 ☐	_____

Do you have:			Further comment if answered yes
Frequent colds	Yes ☐	No ☐	_____
Chronic cough	Yes ☐	No ☐	_____
Shortness of breath when walking or climbing 1 flight of stairs	Yes ☐	No ☐	_____

Do you:			
Wheeze	Yes ☐	No ☐	
Cough up phlegm	Yes ☐	No ☐	
Smoke cigarettes	Yes ☐	No ☐	Packs per day _____ How many years _____

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 _____