SIPS IV mark-up
9/24/18

Part 1

INITIAL MEDICAL QUESTIONNAIRE

1. NAME ____________________

~~2. SOCIAL SECURITY #~~ ____________________

2. ~~3.~~ CLOCK NUMBER ____________________

3. ~~4.~~ PRESENT OCCUPATION ____________________

4. ~~5.~~ PLANT ____________________

5. ~~6.~~ ADDRESS ____________________

6. ~~7.~~ ____________________
(Zip Code)

7. ~~8.~~ TELEPHONE NUMBER ____________________

8. ~~9.~~ INTERVIEWER ____________________

9. ~~10.~~ DATE ____________________

10. ~~11.~~ Date of Birth ____________________
Month Day Year

11. ~~12.~~ Place of Birth ____________________

12. ~~13.~~ Sex
1. Male ___
2. Female ___

13. ~~14.~~ What is your marital status?
1. Single ___
2. Married ___
3. Widowed ___
4. Separated/ Divorced ___

14. ~~15.~~ Race (Check all that apply)
1. White ___
2. Black or African American ___
3. Asian ___
4. Hispanic or Latino ___
5. ~~Indian~~ American Indian or Alaska Native ___
6. ~~Other~~ Native Hawaiian or Other Pacific Islander ___

15. ~~16.~~ What is the highest grade completed in school? ____________________
(For example 12 years is completion of high school)

OCCUPATIONAL HISTORY

16A. ~~17A.~~ Have you ever worked full time (30 hours per week or more) for 6 months or more? 1. Yes _ 2. No__

IF YES TO ~~17A~~: 16A

B. Have you ever worked for a year or more in any dusty job? 1. Yes__ 2.No__ 3.Does Not Apply _

Specify job/industry ____________________ Total Years Worked __

Was dust exposure: 1. Mild ___ 2. Moderate ___ 3. Severe ___

C. Have you even been exposed to gas or chemical fumes in your work? 1. Yes ___ 2. No ___

Specify job/industry ____________________ Total Years Worked ___

Was exposure: 1. Mild ___ 2. Moderate ___ 3. 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 in 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)

Have you ever worked:

		YES	NO
E.	In a mine?	[__]	[__]
F.	In a quarry?	[__]	[__]
G.	In a foundry?	[__]	[__]
H.	In a pottery?	[__]	[__]
I.	In a cotton, flax or hemp mill?	[__]	[__]
J.	With asbestos?	[__]	[__]

All textboxes changed to underlined fields.

17. ~~18.~~ PAST MEDICAL HISTORY

		YES	NO
A.	Do you consider yourself to be in good health?	[__]	[__]
	If "NO" state reason ______________________		
B.	Have you any defect of vision?..................	[__]	[__]
	If "YES" state nature of defect ______________		
C.	Have you any hearing defect?....................	[__]	[__]
	If "YES" state nature of defect ______________		
D.	Are you suffering from or have you ever suffered from:	YES	NO
	a. Epilepsy (or fits, seizures, convulsions)?	[__]	[__]
	b. Rheumatic fever?	[__]	[__]
	c. Kidney disease?	[__]	[__]
	d. Bladder disease?	[__]	[__]
	e. Diabetes?	[__]	[__]
	f. Jaundice?	[__]	[__]

~~19.~~ 18. CHEST COLDS AND CHEST ILLNESSES

~~19A.~~ 18A. If you get a cold, does it "usually" go to your chest? (Usually means more than 1/2 the time)
1. Yes__ 2. No__ 3. Don't get colds__

~~20A.~~ 19A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
1. Yes__ 2. No__

IF YES TO ~~20A~~ 19A:

B. Did you produce phlegm with any of these chest illnesses?
1. Yes__ 2. No__ 3. Does Not 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 ____

20. ~~21.~~ Did you have any lung trouble before the age of 16?
1. Yes__ 2. No__

21. ~~22.~~ Have you ever had any of the following?

1A. Attacks of bronchitis? 1. Yes__ 2. No__
IF YES TO 1A:
B. Was it confirmed by a doctor? 1. Yes__ 2. No__ 3. Does Not Apply _

C. At what age was your first attack? Age in Years __ Does Not Apply _

2A. Pneumonia (include bronchopneumonia)? 1. Yes_ 2. No_
IF YES TO 2A:
B. Was it confirmed by a doctor? 1. Yes__ 2. No__ 3. Does Not Apply _

C. At what age did you first have it? Age in Years __ Does Not Apply _

3A. Hay Fever? 1. Yes__ 2. No__
IF YES TO 3A:
B. Was it confirmed by a doctor? 1. Yes__ 2. No__ 3. Does Not Apply _

C. At what age did it start? Age in Years __ Does Not Apply _

22A. ~~23A.~~ Have you ever had chronic bronchitis? 1. Yes__ 2. No__
IF YES TO ~~23A~~ 22A:
B. Do you still have it? 1. Yes __ 2. No__ 3. Does Not Apply _
C. Was it confirmed by a doctor? 1. Yes__ 2. No__ 3. Does Not Apply _

D. At what age did it start? Age in Years __ Does Not Apply _

23A. ~~24A.~~ Have you ever had emphysema? 1. Yes__ 2. No__
IF YES TO ~~24A~~ 23A:
B. Do you still have it? 1. Yes__ 2. No__ 3. Does Not Apply _

C. Was it confirmed by a doctor? 1. Yes__ 2. No__ 3. Does Not Apply _

D. At what age did it start? Age in Years __ Does Not Apply _

24A. ~~25A.~~ Have you ever had asthma? 1. Yes__ 2. No__
IF YES TO 25A:

B. Do you still have it? 1. Yes__ 2. No__
3. Does Not Apply _

C. Was it confirmed by a doctor? 1. Yes__ 2. No__
3. Does Not Apply _

D. At what age did it start? Age in Years __
Does Not Apply _

E. If you no longer have it, at what age did it stop?
Age stopped __
Does Not Apply _

25. ~~26.~~ Have you ever had:

A. Any other chest illness? 1. Yes__ 2. No__

If yes, please specify ________________________________

B. Any chest operations? 1. Yes__ 2. No__

If yes, please specify ________________________________

C. Any chest injuries? 1. Yes__ 2. No__

If yes, please specify ________________________________

26A. ~~27A.~~ Has a doctor ever told you that you had heart trouble?
1. Yes__ 2. No__

IF YES TO 26A: ~~27A:~~
B. Have you ever had treatment for heart trouble in the past 10 years?
1. Yes__ 2. No__
3. Does Not Apply _

27A. ~~28A.~~ Has a doctor ever told you that you had high blood pressure? 1. Yes__ 2. No__

IF YES TO 27A: ~~28A:~~
B. Have you had any treatment for high blood pressure (hypertension in the past 10 years?
1. Yes__ 2. No__
3. Does Not Apply _

28. ~~29.~~ When did you last have your chest X-rayed?
(Year) __ __ __ __

29. ~~30.~~ Where did you last have your chest X-rayed (if known)?
____

What was the outcome? ____________________

FAMILY HISTORY

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

	FATHER			MOTHER		
	1. Yes	2. No	3. Don't know.	1. Yes	2. No	3. Don't know.
Chronic bronchitis?	___	___	___	___	___	___
Emphysema?	___	___	___	___	___	___
Asthma?	___	___	___	___	___	___
Lung cancer?	___	___	___	___	___	___
Other chest conditions?	___	___	___	___	___	___
F. Is parent currently alive?	___	___	___	___	___	___

G. Please Specify

FATHER	MOTHER
___ Age if Living	___ Age if Living
___ Age at Death	___ Age at Death
___ Don't Know	___ Don't Know

H. Please specify cause of death ____________________ ____________

COUGH

31A. ~~32A.~~ Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.) [If no, skip to question ~~32C.~~ 31C.]

1. Yes __ 2. No __

B. ~~32B.~~ Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week?

1. Yes __ 2. No __

C. Do you usually cough at all on getting up or first thing in the morning?

1. Yes __ 2. No __

D. Do you usually cough at all during the rest of the day or at night?

1. Yes __ 2. No __

IF YES TO ANY OF ABOVE (31A ~~32A~~, B, C, or D), ANSWER THE FOLLOWING.
IF NO TO ALL, CHECK ~~DOES NOT APPLY~~ AND SKIP TO NEXT PAGE

E. Do you usually cough like this on most days for 3 consecutive months or more during the year?

1. Yes __ 2. No __
3. Does not apply __

F. For how many years have you had the cough?

Number of years __
Does not apply __

33A. 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.) (If no, skip to 34C)

1. Yes __ 2. No __

B. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week?

1. Yes __ 2. No __

C. Do you usually bring up phlegm at all on getting up or first thing in the morning?

1. Yes __ 2. No __

D. Do you usually bring up phlegm at all during the rest of the day or at night?

1. Yes __ 2. No __

IF YES TO ANY OF THE ABOVE (33A, B, C, or D), ANSWER THE FOLLOWING:
IF NO TO ALL, CHECK DOES NOT APPLY AND SKIP TO 34A.

E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?

1. Yes __ 2. No __
3. Does not apply __

F. For how many years have you had trouble with phlegm?

Number of years __
Does not apply __

EPISODES OF COUGH AND PHLEGM

34A. Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year?
*(For persons who usually have cough and/or phlegm)

1. Yes __ 2. No __

If YES TO 34A

B. For how long have you had at least 1 such episode per year?

Number of years ___
Does not apply ___

WHEEZING

34A. ~~35A~~. Does your chest ever sound wheezy or whistling
1. When you have a cold? 1. Yes ___ 2. No ___
2. Occasionally apart from colds? 1. Yes ___ 2. No ___
3. Most days or nights? 1. Yes ___ 2. No ___

IF YES TO 1, 2, or 3 in 35A
B. For how many years has this been present?
Number of years ___
Does not apply ___

35A. ~~36A~~. Have you ever had an attack of wheezing that has made you feel short of breath?
1. Yes ___ 2. No ___

IF YES TO ~~36A~~ 35A
B. How old were you when you had your first such attack?
Age in years ___
Does not apply ___

C. Have you had 2 or more such episodes?
1. Yes ___ 2. No ___
3. Does not apply ___

D. Have you ever required medicine or medicine for the(se) attack(s)?
1. Yes ___ 2. No ___
3.Does not apply ___

BREATHLESSNESS

36 ~~37~~. If disabled from walking by any condition other than heart or lung disease, pleasedescribe and proceed to question 39A.

Nature of condition(s) ___

37A. ~~38A~~. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?
1. Yes ___ 2. No ___

IF YES TO ~~38A~~ 37A

B. Do you have to walk slower than people of your age on the level because of breathlessness?
1. Yes ___ 2. No ___

3. Does not apply ___

C. Do you ever have to stop for breath when walking at your own pace on the level?
1. Yes___ 2. No ___
3. Does not apply ___

D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?
1. Yes___ 2. No ___
3. Does not apply ___

E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs?
1. Yes ___ 2. No ___
3. Does not apply ___

TOBACCO SMOKING

~~39A~~ 38A. Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year.)
1. Yes ___ 2. No ___

IF YES TO ~~39A~~ 38A

B. Do you now smoke cigarettes (as of one month age)?
1. Yes ___ 2. No ___
3. Does not apply ___

C. How old were you when you first started regular cigarette smoking?
Age in years ___
Does not apply ___

D. If you have stopped smoking cigarettes completely, how old were you when you stopped?
Age stopped ___
Check if still smoking ___
Does not apply ___

E. How many cigarettes do you smoke per day now?
Cigarettes per day ___
Does not apply ___

F. On the average of the entire time you smoked, how many cigarettes did you smoke per day?
Cigarettes per day ___
Does not apply ___

G. Do or did you inhale the cigarette smoke?
1. Does not apply ___

2. Not at all ___
3. Slightly ___
4. Moderately ___
5. Deeply ___

~~40A~~. 39A. Have you ever smoked a pipe regularly? (Yes means more than 12 oz. of tobacco in a lifetime.)
1. Yes___ 2. No___

IF YES TO ~~40A.~~ 39A

FOR PERSONS WHO HAVE EVER SMOKED A PIPE

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

2. If you have stopped smoking a pipe completely, how old were you when you stopped?
Age stopped ___
Check if still smoking pipe ___
Does not 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.)
___ Does not 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?
1. Never smoked ___
2. Not at all ___
3. Slightly ___
4. Moderately ___
5. Deeply ___

40A. ~~41A~~. Have you ever smoked cigars regularly?
1. Yes___ 2. No___
(Yes means more than 1 cigar a week for a year)

IF YES TO ~~41A~~ 40A

FOR PERSONS WHO HAVE EVER SMOKED CIGARS

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 — ✓ stopped smoking cigars?
   - Age stopped _
   - Check if still smoking cigars _
   - Does not apply _

C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week?
   - Cigars per week ___
   - Does not apply ✓

D. How many cigars are you smoking per week now?
   - Cigars per week _
   - Check if not smoking cigars currently _

E. Do or did you inhale the cigar smoke?
   1. Never smoked _
   2. Not at all _
   3. Slightly _
   4. Moderately _
   5. Deeply _

Signature ______________________ Date ____________

Part 2
PERIODIC MEDICAL QUESTIONNAIRE

1. NAME ______________________________

~~2. SOCIAL SECURITY # _ _ _ _ _ _ _ _ _~~

3. CLOCK NUMBER _ _ _ _ _ _

4. PRESENT OCCUPATION ______________________

5. PLANT ______________________

6. ADDRESS ______________________

7. ______________________ (Zip Code)

8. TELEPHONE NUMBER ______________________

9. INTERVIEWER ______________________

10. DATE ______________________ _ _ _ _ _ _

11. What is your marital status? 1. Single __ 2. Married __ 3. Widowed __ 4. Separated/ Divorced _

12. OCCUPATIONAL HISTORY

12A. In the past year, did you work full time (30 hours per week or more) for 6 months or more? 1. Yes ___ 2. No __

IF YES TO 12A:

12B. In the past year, did you work in a dusty job? 1. Yes ___ 2. No __ 3. Does Not Apply ___

12C. Was dust exposure: 1. Mild __ 2. Moderate __ 3. Severe ___

12D. In the past year, were you exposed to gas or chemical fumes in your work? 1. Yes ___ 2. No ___

12E. Was exposure: 1. Mild __ 2.Moderate __ 3. Severe __

12F. In the past year, what was your:
1. Job/occupation? ________________
2. Position/job title? ____________

13. RECENT MEDICAL HISTORY

13A. Do you consider yourself to be in good health? Yes ___ No ___

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

14A. If you get a cold, does it usually go to your chest? (Usually means more than 1/2 the time)
1. Yes ___ 2. No __
3. Don't get colds __

15A. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
1. Yes ___ 2. No __
3. Does Not Apply __

IF YES TO 15A:

15B. Did you produce phlegm with any of these chest illnesses?
1. Yes ___ 2. No __
3. 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 _

15. ~~16.~~ RESPIRATORY SYSTEM

In the past year have you had:

	Yes or No	Further Comment on Positive Answers
Asthma	____	
Bronchitis	____	
Hay Fever	____	
Other Allergies	____	

	Yes or No	Further Comment on Positive Answers
Pneumonia	____	
Tuberculosis	____	
Chest Surgery	____	
Other Lung Problems	____	
Heart Disease	____	

Do you have:

	Yes or No	Further Comment on Positive Answers
Frequent colds	____	
Chronic cough	____	
Shortness of breath when walking or climbing one flight or stairs	____	

Do you:

Wheeze	____	
Cough up phlegm	____	
Smoke cigarettes	____	Packs per day ___ How many years ___

Date ______________ Signature ________________________