

Occupational Safety and Health Admin., Labor

§ 1915.1001

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 _____ 4. Separated/ Divorced _____
2. Married _____
3. Widowed _____
- 14. ~~15.~~ Race (Check all that apply)
American Indian or Alaska Native
1. White _____ 4. Hispanic _____
2. Black _____ 5. Indian _____
3. Asian _____ 6. Other _____
or African American
or Latino
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?.....	<input type="checkbox"/>	<input type="checkbox"/>
F. In a quarry?.....	<input type="checkbox"/>	<input type="checkbox"/>
G. In a foundry?.....	<input type="checkbox"/>	<input type="checkbox"/>
H. In a pottery?.....	<input type="checkbox"/>	<input type="checkbox"/>
I. In a cotton, flax or hemp mill?.....	<input type="checkbox"/>	<input type="checkbox"/>
J. With asbestos?.....	<input type="checkbox"/>	<input type="checkbox"/>

All text boxes changed to underlined fields.

~~18.~~ PAST MEDICAL HISTORY

17.

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? [] []

CHEST COLDS AND CHEST ILLNESSES

18. 19.
18A.
19A.

19A. 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. 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 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:
- 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:
- 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 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 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.

28. 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 ___ 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.]
 1. Yes ___ 2. No ___

31C. 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 (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

32A. 32A. 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 33C)
 1. Yes *32A* 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

32A
 IF YES TO ANY OF THE ABOVE (32A, B, C, or D), ANSWER THE FOLLOWING:
 IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO 34A. *33A.*

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

33A. 33A. 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 *33A* 2. No

If YES TO 33A
 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

- 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

- 34 37. If disabled from walking by any condition other than heart or lung disease, please describe 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 ~~X~~ 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

- 38A-39A. 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 ago)?
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 _____

39A.

40A. Have you ever smoked a pipe regularly?
 (Yes means more than 12 oz. of tobacco
 in a lifetime.)

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.

41A. Have you ever smoked cigars regularly?
 (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 ____

Occupational Safety and Health Admin., Labor

§ 1915.1001

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? *time you smoked cigars*
- Cigars per week -
Does not apply *f*
- 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 ___ 4. Separated/
2. Married ___ Divorced ___
3. Widowed ___

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 ___

11E. ~~12E.~~ Was exposure: 1. Mild ___ 2. Moderate ___
3. Severe ___

11F. ~~12F.~~ In the past year, what was your: 1. Job/occupation? _____
2. Position/job title? _____

12. ~~12.~~ RECENT MEDICAL HISTORY

12A. ~~12A.~~ Do you consider yourself to be in good health? Yes ___ No ___

If NO, state reason _____

12B. ~~12B.~~ In the past year, have you developed:

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

13. ~~13.~~ CHEST COLDS AND CHEST ILLNESSES

13A. ~~14A.~~ If you get a cold, does it usually go to your chest? (Usually means more than 1/2 the time)
(lower case) 1. Yes ___ 2. No ___
3. Don't get colds ___

14A. ~~15A.~~ During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
14A. 1. Yes ___ 2. No ___
3. Does Not Apply ___

IF YES TO 15A:

14B. ~~15B.~~ Did you produce phlegm with any of these chest illnesses? 1. Yes ___ 2. No ___
3. Does Not Apply ___

14C. ~~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 *x* illnesses ___
removed spaces

15. 16. RESPIRATORY SYSTEM

In the past year have you had:

	<u>Yes or No</u>	<u>Further Comment on Positive Answers</u>
Asthma	_____	
Bronchitis	_____	
Hay Fever	_____	
Other Allergies	_____	

	<u>Yes or No</u>	<u>Further Comment on Positive Answers</u>
Pneumonia	_____	
Tuberculosis	_____	
Chest Surgery	_____	
Other Lung Problems	_____	
Heart Disease	_____	

Do you have:

	<u>Yes or No</u>	<u>Further Comment on Positive Answers</u>
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 _____