

Attachment 16 –
Respiratory Assessment Form – Form No. CDC/NIOSH (M) 2.13

Reset Form

Form Approved
OMB No. 0920-0020

RESPIRATORY ASSESSMENT FORM DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH COAL WORKERS' HEALTH SURVEILLANCE PROGRAM (CWHSP)	Return To: NIOSH Coal Workers' Health Surveillance Program 1095 Willowdale Road, M/S LB208 Morgantown, WV 26505 FAX: 304-285-6058
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Miner Identification		
Miner's Name (Last)	(First)	(Middle)
<input type="text"/>	<input type="text"/>	<input type="text"/>
	Birth Date	Date Completed
	<input type="text"/>	<input type="text"/>
Email Address	<input type="text"/>	
<input type="text"/>		

Mark an X for the best answer.

Medical Conditions		
1. Has a doctor, nurse, or other health professional EVER told you that you had any of the following?		
	NO	YES
Coronary heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
Angina, also called angina pectoris?	<input type="checkbox"/>	<input type="checkbox"/>
A heart attack (myocardial infarction)?	<input type="checkbox"/>	<input type="checkbox"/>
A stroke?	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure or hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
COPD (Chronic Obstructive Pulmonary Disease)?	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory Symptoms		
2. Do you usually have a cough, apart from colds? If YES, answer 2a and 2b.	No <input type="checkbox"/>	Yes <input type="checkbox"/>
2a. Do you cough on <u>most days</u> * for 3 or more months during the year?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
2b. About how many years have you had this cough?	Years <input type="text"/>	
3. Do you usually bring up phlegm from your chest, apart from colds? If YES, answer 3a and 3b.	No <input type="checkbox"/>	Yes <input type="checkbox"/>
3a. Do you bring up chest phlegm on <u>most days</u> * for 3 or more months during the year?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
3b. About how many years have you had phlegm like this?	Years <input type="text"/>	

* = Most days means 4 or more days each week.

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA, 30333, ATTN: PRA (0920-0020).

CDC/NIOSH 2.13 (E), Revised April 2016, CDC Adobe Acrobat 11.0, S508 Electronic Version, April 2016

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Next Page

Respiratory Symptoms (continued)			
4. In the last 12 months, have you had wheezing or whistling in your chest at any time? If YES, answer 4a thru 4c.		No <input type="checkbox"/>	Yes <input type="checkbox"/>
4a. Mark one: Yes, I have wheezing <u>only</u> when I have a cold			Yes <input type="checkbox"/>
OR Yes, I have wheezing sometimes when I don't have a cold			Yes <input type="checkbox"/>
4b. Does the wheezing always clear when you cough?		No <input type="checkbox"/>	Yes <input type="checkbox"/>
4c. When you are away from the mine on days off, is this wheezing or whistling (mark one)		The same <input type="checkbox"/>	Worse <input type="checkbox"/>
5. In the past 12 months, have you had an episode of asthma or an asthma attack?		No <input type="checkbox"/>	Yes <input type="checkbox"/>
5a. If YES, about how old were you when you first had an attack of asthma?		Age	
6. Are you currently taking any medicine for your breathing? (including inhalers, aerosols, or pills)		No <input type="checkbox"/>	Yes <input type="checkbox"/>
6a. If YES, mark what you are currently taking:		Inhalers <input type="checkbox"/>	Aerosols <input type="checkbox"/>
			Pills <input type="checkbox"/>
7. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? If YES, answer 7a.		No <input type="checkbox"/>	Yes <input type="checkbox"/>
7a. Do you have to walk slower than people of your age on level ground because of shortness of breath? If YES, answer 7b.		No <input type="checkbox"/>	Yes <input type="checkbox"/>
7b. About how many years have you had this shortness of breath?		Years	
Smoking History			
8. Have you ever smoked cigarettes regularly? (Mark NO if you smoked less than 100 cigarettes in your entire life; 100 cigarettes = 5 packs) If YES, answer 8a thru 8d.		No <input type="checkbox"/>	Yes <input type="checkbox"/>
8a. On average, for the entire time that you smoked, about how many cigarettes did you smoke per day? (1 pack = 20 cigarettes)		Cigarettes per Day	
8b. About how old were you when you first started smoking cigarettes regularly?		Age	
8c. Do you still smoke cigarettes?		No <input type="checkbox"/>	Yes <input type="checkbox"/>
If NO, about how old were you when you completely stopped smoking?		Age	
If YES, would you like to quit smoking now?		Yes <input type="checkbox"/>	Maybe <input type="checkbox"/>
			No <input type="checkbox"/>
8d. During the time you were a smoker, did you ever stop smoking for 6 months or more?		No <input type="checkbox"/>	Yes <input type="checkbox"/>
If YES, about how long did you stop smoking altogether? (Mark the total number of years that you stopped smoking during the time you were a smoker)			Years
9. Do you use any other inhaled tobacco or nicotine products (pipes, cigars, electronic cigarettes, e-cigarettes etc.)?			No <input type="checkbox"/>
9a. If YES, do you use them (mark one)		Every Day <input type="checkbox"/>	Most Days <input type="checkbox"/>
			Some Days <input type="checkbox"/>

* = Most days means 4 or more days each week.