Attachment 16 –

Respiratory Assessment Form – Form 2.13

Form Approved
OMB No. 0920-0020
Exp. Date xx/xx/20xx

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

Miner Identification

Miner's Name (Last)	(First)	(Middle)
Medical Record Number	Birth Date	Date Completed
Email Address		

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?		
Angina, also called angina pectoris?		
A heart attack (myocardial infarction)?		
A stroke?		
High blood pressure or hypertension?		
Asthma?		
Emphysema?		
Chronic bronchitis?		
Rheumatoid arthritis?		
COPD (Chronic Obstructive Pulmonary Disease)?		

Respiratory Symptoms

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

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

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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 and 4b.			No	Yes
4a. Mark one: Yes, I have wheezing <u>only</u> when I have a cold				Yes
OR Yes, I have wheezing sometimes when I don't have a cold				Yes
4b. Does the wheezing always clear when you cough?			No	Yes
5. When you are away from the mine on days off, is this wheezing or whistling (mark one)	The same		Worse	Better
6. In the past 12 months, have you had an episode of asthma or an asthma attack?			No	Yes
6a. If YES, about how old were you when you first had an attack of asthma?			Age	
7. Are you currently taking any medicine for your breathing? (including inhalers, aerosols, or pills)			No	Yes
7a. If YES, mark what you are currently taking:	Inhalers		Aerosols	Pills
8. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? If YES, answer 8a.			No	Yes
8a. Do you have to walk slower than people of your age on level ground because of shortness of breath? If YES, answer 8b.			No	Yes
8b. About how many years have you had this shortness of breath?			Years	

Smoking History

9. 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 9a thru 9d.			No	Yes
9a. 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	
9b. About how old were you when you first started smoking cigarettes <u>regularly</u>?			Age	
9c. Do you still smoke cigarettes?			No	Yes
If NO, about how old were you when you completely stopped smoking?			Age	
If YES, would you like to quit smoking now?	Yes		Maybe	No
9d. During the time you were a smoker, did you ever stop smoking for 6 months or more?			No	Yes
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
10. Do you use any other inhaled tobacco or nicotine products (pipes, cigars, electronic cigarettes, e-cigarettes etc.)?			No	Yes
10a. If YES, do you use them (mark one)	Every Day		Most Days	Some Days

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