SARATOGA HOSPITAL
MEDICAL GROUP
OCCUPATIONAL MEDICINE
2388 Route 9 • MECHANICVILLE • ny • 12118
Tel: (518) 886-5412 • FAX: (518) 899-8069

DOB: Age: Sex:
ADM/SVC Date: Arrival Time:
Loc:

MR#:

Initial Asbestos Medical Questionnaire

1. Name: _____
2. Social Security #: _____
3. Clock Number: _____
4. Present Occupation: _____
5. Plant: _____
6. Address: _____ Zip: _____
7. Telephone #: _____
8. Interviewer: _____
9. Date: _____ Date of Birth: _____
10. Place of Birth: _____
11. Sex: ☐ Male ☐ Female
12. What is your marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
13. Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Indian ☐ Other: _____
14. What is the highest grade completed in school? _____
    (for example, 12 years is completion of high school)

Occupational History:

15. Have you ever worked full time (30 hours per week or more) for 6 months or more? ☐ Yes ☐ No

    If Yes, have you ever worked for a year or more in any dusty job? ☐ Yes ☐ No ☐ N/A

    a) Have you ever worked for a year or more in a dusty job? ☐ Yes ☐ No ☐ N/A

       Specify job/industry: _____ Total years worked: _____

    b) Was dust exposure: ☐ Mild ☐ Moderate ☐ Severe

    c) Have you ever been exposed to gas or chemical fumes in your work? ☐ Yes ☐ No

       Specify job/industry: _____ Total years worked: _____

    d) Was chemical exposure: ☐ Mild ☐ Moderate ☐ Severe

    e) What has been your usual occupation or job – the one you have worked the longest?

       1. Job Occupation: _____
       2. Number of years employed in this occupation: _____
       3. Position/job title: _____
       4. Business, field or industry: _____

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Initial Medical Questionnaire

*Record on the lines next to each question below, the years in which you have worked in any of these industries, e.g., 1960-1969.

Have you ever worked:

f)	In a mine?	☐ Yes	☐ No
g)	In a quarry?	☐ Yes	☐ No
h)	In a foundry?	☐ Yes	☐ No
i)	In a pottery?	☐ Yes	☐ No
j)	In a cotton, flax or hemp mill?	☐ Yes	☐ No
k)	With asbestos?	☐ Yes	☐ No

16. Past Medical History:

a)	Do you consider yourself to be in good health?	☐ Yes	☐ No
	If No, state reason: _____		
b)	Have you any defect of vision?	☐ Yes	☐ No
	If Yes, state nature of defect: _____		
c)	Have you any hearing defect?	☐ Yes	☐ No
	If Yes, state nature of defect: _____		
d)	Are you suffering from or have you ever suffered from:		
	1. Epilepsy (or fits, seizures, convulsions)	☐ Yes	☐ No
	2. Rheumatic fever?	☐ Yes	☐ No
	3. Bladder disease?	☐ Yes	☐ No
	4. Diabetes?	☐ Yes	☐ No
	5. Jaundice?	☐ Yes	☐ No

17. Chest Colds and Chest Illnesses:

a)	If you get a cold, does it "usually" go to your chest? (usually means more than ½ the time).	☐ Yes	☐ No	
b)	During the last 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?	☐ Yes	☐ No	
	If Yes, did you produce phlegm with an of these chest illnesses	☐ Yes	☐ No	☐ N/A
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			

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Initial Medical Questionnaire

18. Did you have any lung trouble before the age of 16 ☐ Yes ☐ No

19. Have you ever had any of the following:

a) Attacks of bronchitis? ☐ Yes ☐ No

If Yes, was it confirmed by doctor? ☐ Yes ☐ No

If Yes, at what age was your first attack: ____ Age in years

b) Pneumonia (include bronchopneumonia)? ☐ Yes ☐ No

If Yes, was it confirmed by a doctor? ☐ Yes ☐ No

If Yes, at what age did you first have it: ____ Age in years

c) Have fever? ☐ Yes ☐ No

If Yes, was it confirmed by a doctor? ☐ Yes ☐ No

If Yes, at what age did it start: _____ Age in years ☐ Yes ☐ No

20. Have you ever had chronic bronchitis? ☐ Yes ☐ No

If Yes, do you still have it? ☐ Yes ☐ No

If Yes, was it confirmed by a doctor? ☐ Yes ☐ No

If Yes, at what age did it start: _____ Age in years

21. Have you ever had emphysema? ☐ Yes ☐ No

If Yes, do you still have it? ☐ Yes ☐ No

If Yes, was it confirmed by a doctor? ☐ Yes ☐ No

If Yes, at what age did you first have it: ____ Age in years

22. Have you ever had asthma? ☐ Yes ☐ No

If Yes, do you still have it? ☐ Yes ☐ No

If Yes, was it confirmed by a doctor? ☐ Yes ☐ No

If Yes, at what age did you first have it: ____ Age in years

If you no longer have it, at what age did you stop? ____ Age in years

23. Have you ever had:

a) Any other chest illnesses? ☐ Yes ☐ No

If Yes, please specify: _____

b) Any chest problems? ☐ Yes ☐ No

If Yes, please specify: _____

c) Any chest injuries? ☐ Yes ☐ No

If Yes, please specify: _____

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Initial Medical Questionnaire

24. Has a doctor ever told you that you had heart trouble? ☐ Yes ☐ No

    If Yes, have you ever had treatment for heart trouble in the past 10 years? ☐ Yes ☐ No

25. Has a doctor told you that you had high blood pressure? ☐ Yes ☐ No

    If Yes, have you had any treatment for high blood pressure (hypertension) in the past 10 years? ☐ Yes ☐ No

26. When did you last have your chest X-rayed?

    Year: _____ Where was it taken (if known)? _____

Family History:

27. Were either of your natural parents ever told by a doctor that they had a chronic lung condition? Mother: ☐ Yes ☐ No; Father: ☐ Yes ☐ No

Such as:

a) Chronic Bronchitis? Mother: ☐ Yes ☐ No; Father: ☐ Yes ☐ No

b) Emphysema? Mother: ☐ Yes ☐ No; Father: ☐ Yes ☐ No

c) Asthma? Mother: ☐ Yes ☐ No; Father: ☐ Yes ☐ No

d) Lung Cancer? Mother: ☐ Yes ☐ No; Father: ☐ Yes ☐ No

e) Other Chest Conditions? Mother: ☐ Yes ☐ No; Father: ☐ Yes ☐ No

f) Is parent currently alive? Mother: ☐ Yes ☐ No; Father: ☐ Yes ☐ No

g) Please Specify:

Mother:	**Father:**
☐ 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:

28. Do you usually have a cough? (count a cough with first smoke or on first going out of doors. Exclude clearing of throat). ☐ Yes ☐ No

    (If No, skip to question 28b)

    a) Do you usually cough as much as 4 to 6 times a day or 4 or more times a week? ☐ Yes ☐ No

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b) Do you usually cough at all on getting up or first thing in the morning? ☐ Yes ☐ No

c) Do you usually cough at all during the rest of the day or at night? ☐ Yes ☐ No

IF YES TO (28a,b,c) ANSWER (29a,b,c,d,e)
IF NO TO ALL, CHECK CHECK BOX AND SKIP TO 30:

29. Do you usually bring up phlegm from you chest? ☐ Yes ☐ No ☐ Does not apply

(count phlegm with the first smoke or on first going out of doors.

Exclude phlegm from the nose. Count swallowed phlegm.) ☐ Yes ☐ No ☐ Does not apply

(If No, skip to 33b)

a) Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week? ☐ Yes ☐ No ☐ Does not apply

b) Do you usually bring up phlegm at all on getting up or first thing in the morning? ☐ Yes ☐ No ☐ Does not apply

c) Do you usually bring up phlegm at all during the rest of the day or at night? ☐ Yes ☐ No ☐ Does not apply

d) Do you bring up phlegm like this on most days for 3 consecutive months or more during the year? ☐ Yes ☐ No ☐ 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:

30. 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) ☐ Yes ☐ No ☐ Does not apply

If Yes, for how long have you had at least 1 such episode per year? _____ number of years ☐ Does not apply

WHEEZING:

31. Does your chest ever sound wheezy or whistling:

1. When you have a cold? ☐ Yes ☐ No
2. Occasionally apart from colds? ☐ Yes ☐ No
3. Most days or nights? ☐ Yes ☐ No

If Yes to any in 1, 2, 3 for how many years has this been present? _____ number of years ☐ Does not apply

32. Have you ever had an attack of wheezing that has made you feel short of breath? ☐ Yes ☐ No

If yes:

a) How old were you when you had your first attack? _____ age in years ☐ Does not apply

b) Have you had 2 or more such episodes? ☐ Yes ☐ No

c) Have you ever required medicine or treatment for the(se) attacks? ☐ Yes ☐ No ☐ Does not apply

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BREATHLESSNESS:

33. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 35

Nature of condition(s): _____

_____

34. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill? ☐ Yes ☐ No

If Yes:

a) Do you have to walk slower than people of your age on the level because of breathlessness? ☐ Yes ☐ No ☐ Does not apply

b) Do you have to stop for breath when walking at your own pace on level? ☐ Yes ☐ No ☐ Does not apply

c) Do you ever have to stop for breath after walking about 100 yard (or after a few minutes) on the level? ☐ Yes ☐ No ☐ Does not apply

d) Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs? ☐ Yes ☐ No ☐ Does not apply

TOBACCO SMOKING:

35. 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.) ☐ Yes ☐ No

If Yes:

a) Do you now smoke cigarettes (as of one month ago) ☐ Yes ☐ No ☐ Does not apply

b) How old were you when you first started regular cigarette smoking _____age in years ☐ Does not apply

c) If you have stopped smoking cigarettes completely, how old were you when you stopped? _____age in years ☐ Does not apply

d) How many cigarettes do you smoke per day now? _____# per day ☐ Does not apply

e) On the average of the entire time you smoked, how many cigarettes did you smoke per day? _____# per day ☐ Does not apply

f) Do or did you inhale the cigarette smoke? ☐ "DOES NOT APPLY" ☐ Not at all ☐ Slightly ☐ Moderately ☐ Deeply

36. Have you ever smoked a pipe regularly? (Yes means more than 12 oz. of tobacco in a lifetime.) ☐ Yes ☐ No

If Yes:

a) How old were you when you started to smoke a pipe regularly? _____age in years ☐ Does not apply

b) If you have stopped smoking a pipe completely, how old were you when you stopped? ☐ Check if still smoking pipe _____age in years ☐ Does not apply

c) On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week? (a standard pouch of tobacco contains 1 ½ oz.) ____oz. per week ☐ Does not apply

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d) How much pipe tobacco are you smoking now? ___oz. per week ☐ Does not apply

e) Do you or did you inhale the pipe smoke? ☐ "DOES NOT APPLY" ☐ Not at all ☐ Slightly ☐ Moderately ☐ Deeply

FORM PERSON WHO EVER SMOKED CIGARS:

37. Have you ever smoked cigars regularly?
(Yes means more than 1 cigar a week for a year) ☐ Yes ☐ No

If Yes:

a) How old were you when you started smoking cigars regularly? _____age in years ☐ Does not apply

b) If you have stopped smoking cigars completely, how old were you when you stopped? _____age in years ☐ Does not apply

c) On the average over the entire time you smoked cigars, how many cigars did you smoke per week? _____# per week ☐ Does not apply

d) How many cigars are you smoking per week now? _____# per week ☐ Does not apply

e) Do or did you inhale the cigar smoke? ☐ "DOES NOT APPLY" ☐ Not at all ☐ Slightly ☐ Moderately ☐ Deeply

Signature: _____ Date/Time: _____/_____