



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#: _____

13. Chest Colds and Chest Illnesses:

- a) If you get a cold, does it 'usually' go to your chest? Yes No
- b). During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? Yes No
- c) In the past year how many such illnesses? _____ number of illnesses No such illnesses
 Illnesses with (increased) phlegm? _____ number of illnesses No such illnesses
 Illnesses you had which lasted a week or more? _____ number of illnesses No such illnesses

14. Respiratory System:

In the past year have you had:

- Asthma: Yes No If Yes, Comment: _____
- Bronchitis: Yes No If Yes, Comment: _____
- Hay Fever: Yes No If Yes, Comment: _____
- Other Allergies: _____
- Pneumonia: Yes No If Yes, Comment: _____
- Tuberculosis: Yes No If Yes, Comment: _____
- Chest Surgery: Yes No If Yes, Comment: _____
- Other Lung Problems: _____
- Heart Disease: Yes No If Yes, Comment: _____

Do you have:

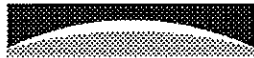
- Frequent Colds: Yes No If Yes, Comment: _____
- Chronic Cough: Yes No If Yes, Comment: _____
- Shortness of breath when walking or climbing one flight or stairs?
 Yes No If Yes, Comment: _____

Do you:

- Wheeze: Yes No If Yes, Comment: _____
- Cough up phlegm: Yes No If Yes, Comment: _____
- Smoke Cigarettes: Yes No If Yes, Comment: _____

Print Name: _____

Signature: _____ Date/Time: _____ / _____



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Asbestos Periodic Questionnaire

1. Name: _____
2. Social Security #: _____
3. Clock Number: _____
4. Present Occupation: _____
5. Plant: _____
6. Address: _____ Zip: _____
7. Telephone #: _____
8. Interviewer: _____
9. Date: _____
10. What is your marital status? Single Married Widowed Separated Divorced
11. Occupational History:
 - a) In the past year, did you work full time (30 hours per week or more) for 6 months or more Yes No
 - b) In the past year, did you work in a dusty job? Yes No
If Yes, was dust exposure: Mild Moderate Severe
 - c) In the past year, were you exposed to gas or chemical fumes in your work? Yes No
If Yes, was Exposure: Mild Moderate Severe
 - d) In the past year what was your:
Job occupation: _____ Position/job title? _____
12. Recent Medical History:
 - a) Do you consider yourself to be in good health? Yes No
If No, state reason: _____
 - b) In the past year, have you developed:

Epilepsy:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic fever:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney disease:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bladder disease:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Jaundice:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer:	<input type="checkbox"/> Yes	<input type="checkbox"/> No