APPENDIX D
FEDERAL REGISTER 1910.1001

PERIODIC ASBESTOS MEDICAL QUESTIONNAIRE

1. Name: _____
2. Social Security#: _____
3. Date: _____
4. Present Occupation: _____
5. Company: _____
6. Address: _____
   _____ Zip: _____
7. Telephone Number: _____
8. Doctor: _____
9. What is your marital status? ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

OCCUPATIONAL HISTORY

10. In the past year, did you work full time (30 hours per week or more) for 6 months or more?
    Yes ☐ No ☐

    If YES to 11:

11. In the past year, did you work in a dusty job? Yes ☐ No ☐ Does not apply ☐

12. Was dust exposure: ☐ Mild ☐ Moderate ☐ Severe

13. In the past year, were you exposed to gas or chemical fumes in your work? Yes ☐ No ☐

14. Was exposure: ☐ Mild ☐ Moderate ☐ Severe

15. In the past year, what was your:
    1. Job/Occupation: _____
    2. Position/Job Title: _____

RECENT MEDICAL HISTORY

16. Do you consider yourself to be in good health? Yes ☐ No ☐
    If no, state reason: _____

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17. In the past year, have you developed?

	Yes	No
Epilepsy	☐	☐
Rheumatic fever	☐	☐
Kidney disease	☐	☐
Bladder disease	☐	☐
Diabetes	☐	☐
Jaundice Cancer	☐	☐

CHEST COLDS AND CHEST ILLNESS

18. If you get a cold, does it usually go to your chest? (usually means more than ½ the time)
☐ Yes ☐ No ☐ Don't get colds

19. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? ☐ Yes ☐ No ☐ Does not apply

20. Did you produce phlegm with any of these illnesses? ☐ Yes ☐ No ☐ Does not apply

21. 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 illnesses ☐

RESPIRATORY SYSTEM

	Yes	No
Asthma	☐	☐
Bronchitis	☐	☐
Hay Fever	☐	☐
Other Allergies	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Chest Surgery	☐	☐
Other Lung Problems	☐	☐
Heart Disease	☐	☐

Further Comment on Positive Answers: _____

_____

Do you have:

Frequent Colds ☐ Yes ☐ No
Chronic Cough ☐ Yes ☐ No
Shortness of breath when walking or climbing one flight of stairs? Yes ☐ No ☐

Further Comment on Positive Answers: _____

_____

Do you:	Yes	No
Wheeze		
Cough up Phlegm		
Smoke Cigarettes	Pack(s) per day_____	How many years _____

Signature:_____Date: _____

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