Holland Medicenter

335 N. 120th Ave • Holland, MI 49424
Phone: (616)392-5222 • Fax: (616) 392-8905

Asbestos Initial Medical Questionnaire

Name:_____ DOB:_____ SSN:_____

Place of Birth:_____ Sex:_____ Marital Status:_____ Highest grade completed in school: _____

Employer:_____ Job Title:_____

OCCUPATIONAL HISTORY

1. Have you ever worked full time (≥ 30 hrs/week) for 6 months or more? Yes_____ No_____

IF YES TO #1:

A. Have you ever worked for a year or more in a dusty job? Yes_____ No_____

Specify job/industry_____ Total Years worked_____

Was dust exposure: Mild_____ Moderate_____ Severe_____

B. Have you ever been exposed to gas or chemical fumes in your work? Yes_____ No_____

Specify job/industry_____ Total Years worked_____

Was dust exposure: Mild_____ Moderate_____ Severe_____

C. What has been your usual occupation or job - the one you have worked at longest?

Job occupation_____ # of years employed in this occupation_____

Position/job title_____ Business, field, or industry_____

2. Record on lines the years in which you worked in any of these industries (example… 1960-1969)

Have you ever worked:

In a mine? …… Yes _____ No _____

In a quarry? …… Yes _____ No _____

In a foundry? …… Yes _____ No _____

In pottery? …… Yes _____ No _____

In a cotton, flax, or hemp mill?……. Yes _____ No _____

With asbestos?…….. Yes _____ No _____

PAST MEDICAL HISTORY

1. Do you consider yourself to be in good health? Yes _____ No _____

If "No", state reason _____

2. Have you any defect in vision? Yes _____ No _____

If "Yes", state nature of defect _____

3. Have you any hearing defect? Yes _____ No _____

If "Yes", state nature of defect _____

4. Are you suffering or have you ever suffered from:

Epilepsy (or fits, seizures, convulsions) Yes _____ No _____

Rheumatic fever? Yes _____ No _____

Kidney disease? Yes _____ No _____

Bladder disease? Yes _____ No _____

Diabetes? Yes _____ No _____

Jaundice? Yes _____ No _____

FAMILY HISTORY

1. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

	FATHER			MOTHER		
	Yes	No	Unsure	Yes	No	Unsure
A. Chronic Bronchitis	___	___	___	___	___	___
B. Emphysema	___	___	___	___	___	___
C. Asthma	___	___	___	___	___	___
D. Lung cancer	___	___	___	___	___	___
E. Other chest conditions	___	___	___	___	___	___
F. Is parent currently alive?	___	___	___	___	___	___
G. Please Specify	_____ Age if Living			_____ Age if Living		
	_____ Age at Death			_____ Age at Death		
	_____ Don't Know			_____ Don't Know		
Cause of Death	_____			_____		

PULMONARY HISTORY

1. If you get a cold, does it "usually" go to your chest? (usually means more than ½ the time) Yes _____ No _____
2. Did you have any lung trouble before the age of 16? Yes _____ No _____
3. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? Yes _____ No _____

   IF YES TO #3:

   A. Did you produce phlegm with any of the chest illnesses? Yes _____ No _____

   B. In the last 3 years, how many such illnesses with (increased) phlegm did you have that lasted a week or more? Number of illnesses _____ No such illnesses _____
4. Have you ever had any of the following?

   A. Attacks of bronchitis? Yes _____ No _____

   IF YES TO 4A: Was it confirmed by a doctor? Yes _____ No _____

   At what age was your first attack? Age in years:_____

   B. Pneumonia? Yes _____ No _____

   IF YES TO 4B: Was it confirmed by a doctor? Yes _____ No _____

   At what age did you first have it? Age in years:_____

   C. Hay Fever? Yes _____ No _____

   IF YES TO 4C: Was it confirmed by a doctor? Yes _____ No _____

   At what age did it start? Age in years:_____
5. Have you ever had chronic bronchitis? Yes _____ No _____

   IF YES TO #5: A. Do you still have it? Yes _____ No _____

   B. Was it confirmed by a doctor? Yes _____ No _____

   C. At what age did it start? Age in years:_____
6. Have you ever had emphysema? Yes _____ No _____

   IF YES TO #6: A. Do you still have it? Yes _____ No _____

   B. Was it confirmed by a doctor? Yes _____ No _____

   C. At what age did it start? Age in years:_____

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

IF YES TO #7:
A. Do you still have it? Yes ☐ No ☐
B. Was it confirmed by a doctor? Yes ☐ No ☐
C. At what age did it start? Age in years:_____
D. If resolved, when did it stop? Age stopped:_____

8. Have you ever had:
A. Any other chest illness? Yes ☐ No ☐

If yes, please specify _____

B. Any chest operations? Yes ☐ No ☐

If yes, please specify _____

C. Any chest injuries? Yes ☐ No ☐

If yes, please specify _____

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

IF YES TO #9, Have you ever had treatment for it in the past 10 years? Yes ☐ No ☐

10. Has a doctor told you that you have high blood pressure? Yes ☐ No ☐

IF YES TO # 10, Have you had any treatment for it in the past 10 years? Yes ☐ No ☐

11. When did you last have chest x-rayed? Year _____

12. Where was your last chest x-rayed (If known) _____ What was the outcome? _____

13. Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude cleaning the throat). Yes ☐ No ☐

14. Do you usually cough as much as 4 - 6 times a day for 4 or more days out of the week? Yes ☐ No ☐

15. Do you usually cough at all on getting or first thing in the morning? Yes ☐ No ☐

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

IF YES TO ANY OF THE ABOVE (QUESTION 13-16), PLEASE ANSWER THE FOLLOWING. IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO QUESTION 26.

17. Do you cough like this on most days for 3 consecutive months or more during the year? Yes ☐ No ☐

18. For how many years have you had the cough? Number of years:_____

19. Do you usually bring up phlegm from your chest? (Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) Yes ☐ No ☐

20. Do you bring up phlegm as much as twice a day for 4 or more days out of the week? Yes ☐ No ☐

21. Do you usually bring up phlegm at all on getting up or first thing in the morning? Yes ☐ No ☐

22. Do you usually bring up phlegm at all during the rest of the day or at night? Yes ☐ No ☐

IF YES TO ANY OF THE ABOVE (QUESTIONS 18-21), PLEASE ANSWER THE FOLLOWING. IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO QUESTION 26.

23. Do you bring up phlegm on most days for 3 consecutive months or more during the year? Yes ☐ No ☐

24. For how many years have you had problems with phlegm? Number of years:_____

25. Have you had periods of (increased*) cough and phlegm lasting for 3 weeks or more each year? **For people who usually have cough/phlegm.* Yes ☐ No ☐

A. For how long have you had at least 1 such episode per year? Number of years:_____

26. Does your chest ever sound wheezy or whistling:
A. When you have a cold? Yes ☐ No ☐
B. Occasionally apart from colds? Yes ☐ No ☐
C. Most days or nights? Yes ☐ No ☐

IF YES TO ANY OF THE ABOVE (A, B, OR C), how many years has this been present? Number of years _____

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

A. How old were you when you had your first attack? Number of years:_____

B. Have you had 2 or more such episodes? Yes _____ No _____

C. Have you ever required medicine or treatment for the(se) attack (s)? Yes _____ No _____

28. If disabled from walking any condition other than heart or lung disease, please describe and proceed to question 30.

Nature of condition(s)_____

29. Are you troubled by shortness of breath when hurrying or walking up a slight hill? Yes _____ No _____

A. Do you have to walk slower than people your age because of breathlessness? Yes _____ No _____

B. Do you ever have to stop for breath when walking at your own pace? Yes _____ No _____

C. Do you ever have to stop for breath after walking about 100 yards (or a few minutes)? Yes _____ No _____

D. Are you too breathless to leave the house, or on dressing or climbing one flight of stairs? Yes _____ No _____

30. 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 TO 30: A. Do you now smoke cigarettes (as of 1 month ago)? Yes _____ No _____

B. How old were you when you first started regular cigarette smoking? Age in years _____

C. If you stopped smoking completely, how old were you when you stopped? Age in years _____

D. How many cigarettes do you smoke a day now? Cigarettes/day _____

E. Over the entire time you smoked, how many cigarettes smoked per day? Cigarettes/day _____

F. Do you or did you inhale the cigarette smoke? Slightly _____ Moderately _____

Deeply _____ Not at all _____

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

IF YES TO QUESTION 31:

A. How old were you when you started to smoke regularly? Age _____

B. If you have stopped smoking completely, how old were you when you stopped? Age _____

C. On the average over the entire time you smoked, how much pipe tobacco did you smoke per week? (a standard pouch of tobacco contains 1 ½ oz.) Oz. per week _____

D. How much pipe tobacco are you smoking now? Oz. per week _____

E. Do you or did you inhale the pipe smoke? Never smoked _____ Not at all _____

Slightly _____ Moderately _____ Deeply _____

32. Have you smoked cigars regularly? (more than 1 cigar per week for 1 year) Yes _____ No _____

IF YES TO QUESTION #32:

A. How old were you when you started to smoke regularly? Age _____

B. If you have stopped smoking cigars completely, how old were you when you stopped? Age _____

C. On the average over the entire time you smoked, how many cigars did you smoke per week? _____/wk

D. How many cigars are you smoking per week now? _____/wk

E. Do you or did you inhale the cigar smoke? Never smoked _____ Not at all _____

Slightly _____ Moderately _____ Deeply _____

I certify that I have answered truthfully questions regarding my health history and have not knowingly withheld any information concerning my health status or exposure to chemicals either past or present.

_____ _____

Signature Date

Holland Medicenter

335 N. 120th Ave • Holland, MI 49424
Phone: (616)392-5222 • Fax: (616) 392-8905

Medical History For Respirator Physical

Employer:_____ Date: _____

Employee:_____ DOB:_____ SS#: _____

Sex:_____ Height:_____ Weight:_____ Job Title: _____

Phone number:_____ Best Time You Can Be Reached At This Number: _____

Has your employer told you how to contact the healthcare professional who will review this questionnaire? ☐ Yes ☐ No

Check the type of respirator you will use (you can check more than one category):

A:_____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

B:_____ Other type (for example, half- or full-facepiece type, powered air Purifying, supplied air, self-contained breathing apparatus).

Have you ever worn a respirator: ☐ Yes ☐ No

If "Yes", what type(s): _____

Questions 1 through 9 below must be answered by every employee who has been selected to use any type or respirator. Please circle "Yes" or "No".

Yes	NO	
____	____	1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?
		2. Have you ever had any of the following conditions?
____	____	Seizures (fits)
____	____	Diabetes (sugar diabetes)
____	____	Allergic reaction that interfered with your breathing
____	____	Claustrophobia (fear of closed-in spaces)
____	____	Trouble smelling odors
		3. Have you ever had any of the following pulmonary or lung problems?
____	____	Asbestosis
____	____	Asthma
____	____	Chronic Bronchitis
____	____	Emphysema
____	____	Pneumonia
____	____	Tuberculosis
____	____	Silicosis
____	____	Pneumothorax (collapsed lung)
____	____	Lung Cancer
____	____	Broken Ribs
____	____	Any chest injuries or surgeries
____	____	Any other lung problem that you've been told about
		4. Do you currently have any of the following symptoms of pulmonary or lung illnesses?
____	____	Shortness of breath
____	____	Shortness of breath when walking fast on level ground or walking up a slight hill or incline.
____	____	Shortness of breath when walking with people at an ordinary pace on level ground.
____	____	Have to stop for breath when walking at an ordinary pace on level ground.
____	____	Shortness of breath when washing or dressing self.

Yes	No	
____	____	Shortness of breath that interferes with your job.
____	____	Coughing that produces phlegm (thick sputum).
____	____	Coughing that wakes you early in the morning.
____	____	Coughing that occurs mostly when you are lying down.
____	____	Coughing up blood in the last month.
____	____	Wheezing.
____	____	Wheezing that interferes with your job.
____	____	Chest pain when you breathe deeply.
____	____	Any other symptoms that you think may be related to lung problems.

5. Have you ever had any of the following cardiovascular or heart problems?

____	____	Heart attack.
____	____	Stroke.
____	____	Angina.
____	____	Heart failure.
____	____	Swelling in your legs or feet (not caused by walking).
____	____	Heart arrhythmia (heart beating irregularly).
____	____	High blood pressure.
____	____	Any other heart problem you have been told about.

6. Have you ever had any of the following cardiovascular or heart symptoms?

____	____	Frequent pain or tightness in the chest.
____	____	Pain or tightness in your chest during physical activity.
____	____	Pain or tightness in your chest that interferes with your job.
____	____	In the past two years, have you noticed your heart skipping or missing a beat.
____	____	Heartburn or indigestion that is not related to eating.
____	____	Any other symptoms you think may be related to heart or circulation problems.

7. Do you currently take medication for the following problems?

____	____	Breathing or lung problems.
____	____	Heart trouble.
____	____	Blood pressure.
____	____	Seizures (fits).

8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check the following space and go to question 9)

____	____	Eye irritation.
____	____	Skin allergies or rashes.
____	____	Anxiety.
____	____	General weakness or fatigue.
____	____	Any other problems that interferes with your use of the respirator.

____	____	9. Would you like to talk to the health care professional who will receive this questionnaire about your answers to the questionnaire?

Questions 10 to 15 must be answered by every employee who has been selected to use either a full-face respirator or a self contained breathing apparatus (SCBA). For employees who have been asked to use other types of respirators, answering these questions is voluntary.

____	____	10. Have you ever lost vision in either eye (temporarily or permanently)?

Yes	No	
		11. Do you currently have any of the following vision problems?
		Wear contact lenses.
		Wear glasses.
		Color blind.
		Any other eye or vision problems.
		12. Have you ever had an injury to your ears, including a broken ear drum?
		13. Do you currently have any of the following hearing problems?
		Difficulty hearing.
		Wear a hearing aid.
		Any other hearing or ear problem.
		14. Have you ever had a back injury?
		15, Do you currently have any of the following musculoskeletal problems?
		Weakness in any of your arms, hands, legs, or feet.
		Back pain.
		Difficulty fully moving your arms or legs.
		Pain or stiffness when you lean forward or backward at the waist.
		Difficulty bending at the knees.
		Difficulty squatting to the ground.
		Climbing a flight of stairs or a ladder carrying more than 25 lbs.
		Any other muscle or skeletal problem that interferes with using a respirator.
		16. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?
		If "Yes", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these circumstances?
		17. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (Example: gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?

If "Yes", What? _____

		18. Have you ever worked with any of the materials, or under any of the conditions listed below?
		Asbestos.
		Silica (ex. in sandblasting).
		Tungsten/cobalt (ex. grinding or welding this material).
		Beryllium.
		Aluminum.
		Coal (ex. mining).
		Iron.
		Tin.
		Dusty environments.
		Any other hazardous exposure.

If "Yes", describe these exposures: _____

		19. Have you been in the military services?
		If "Yes", were you exposed to biological or chemical agents (either in training or combat)?

20. List any previous occupations including second jobs and side businesses:

Yes	No	
____	____	21. Are you taking any other medications other than the ones mentioned above?

If "Yes", name the medication if you know them: _____

22. Will you be using any of the following items with your respirator?

____	____	HEPA Filters.
____	____	Canisters (for example, gas masks).
____	____	Cartridges.

23. How often are you expected to use the respirator(s) (circle "Yes" or "No" for all that apply to you.

____	____	Escape only (no rescue).
____	____	Emergency rescue only.
____	____	Less than 5 hours per week.
____	____	Less than 2 hours per day.
____	____	2 to 4 hours per day.
____	____	Over 4 hours per day.

24. During the period you are using the respirator(s), is your work effort:

____	____	Light (less than 200 Kcal per hour)

If "Yes", how long does this period last during the average shift:_____hrs_____mins.

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

____	____	Moderate (200 – 350 kcal per hour)

If "Yes", how long does this period last during the average shift:_____hrs_____mins.

Examples of moderate work effort are sitting while nailing or filing, driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

____	____	Heavy (above 350 kcal per hour)

If "Yes", how long does this period last during the average shift:_____hrs_____mins.

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

____	____	25. Will you be wearing other protective clothing and/or equipment when using the respirator?

If "Yes", describe this protective clothing and/or equipment: _____

____	____	26. Will you be working under hot or humid conditions?

27. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases): _____

I certify that I have answered truthfully questions regarding my health history and have not knowingly withheld any information concerning my health status or exposure to chemicals either past or present.

_____ _____

EMPLOYEE SIGNATURE DATE

PFT Questionnaire

Name _____ **Today's Date** _____

Employer_____ **Birth Date**_____**SSN**_____

Race: ☐ African-American ☐ Caucasian ☐ Hispanic ☐ Other: _____

1. Smoking? ☐ Never ☐ Quit <1 yr ☐ Quit 1+ yrs ☐ Smoker
2. Have you experienced any new chest or breathing problems in the last month?..... ☐ YES ☐ NO
3. Are you in pain or do you feel ill in anyway?..... ☐ YES ☐ NO
4. Have you had any surgery or hospitalization in the past 4 weeks?..... ☐ YES ☐ NO
5. Have you eaten a large meal in the past hour?..... ☐ YES ☐ NO
6. Have you exercised vigorously in the past hour?..... ☐ YES ☐ NO
7. Do you currently have allergies that affect nose/sinus/breathing (hay fever)?..... ☐ YES ☐ NO
8. Do you have asthma?..... ☐ YES ☐ NO
9. Do you have a respiratory infection?..... ☐ YES ☐ NO
10. Have you had influenza or severe cold in the past 3 weeks?..... ☐ YES ☐ NO
11. Are you wearing any tight or restrictive clothing?..... ☐ YES ☐ NO
12. Have you used inhaler (bronchodialator) in the past hour?..... ☐ YES ☐ NO
13. Do you have a chronic cough (every day for the past 2months)?..... ☐ YES ☐ NO

Please remove anything you may have in your mouth including gum, candy, tongue ring, etc.

I herby certify that I have fully read the above questions and that my answers are true and correct.

Employee Signature _____ Date _____