



Occupational  
Medicine  
Services

Bethesda Care Arrow Springs  
Phone: 513-282-7075  
Fax: 513-282-7076

Bethesda Care Butler County  
Phone: 513-874-3990  
Fax: 513-860-5071

Bethesda Care Eastgate  
Phone: 513-752-3695  
Fax: 513-752-3039

Bethesda Care Norwood  
Phone: 513-731-3399  
Fax: 513-731-2882

Bethesda Care Queensgate  
Phone: 513-241-4135  
Fax: 513-241-6510

Bethesda Care Sharonville  
Phone: 513-563-1505  
Fax: 513-769-4776

Good Samaritan  
Phone: 513-862-2875  
Fax: 513-862-2860

### INITIAL ASBESTOS MEDICAL QUESTIONNAIRE

Date: \_\_\_\_\_

Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Sex:  Male  Female

County \_\_\_\_\_ State \_\_\_\_\_  
Marital Status:  Married  Widowed  Separated/Divorced

Race:  Caucasian  Black  Asian  Hispanic  Native American  Other: \_\_\_\_\_

Highest Grade Completed in School:  High School \_\_\_\_ (years)  College \_\_\_\_ (years)  Graduate

Name of High School: \_\_\_\_\_

Occupation: \_\_\_\_\_ Name of Company: \_\_\_\_\_

Company Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Work Telephone: \_\_\_\_\_

### OCCUPATIONAL HISTORY

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

Specify job/industry: \_\_\_\_\_ Total years worked: \_\_\_\_\_

Describe dust exposure:  Mild  Moderate  Severe

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

Specify job/industry: \_\_\_\_\_ Total years worked: \_\_\_\_\_

Describe exposure:  Mild  Moderate  Severe

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

Job Occupation: \_\_\_\_\_ Total years worked: \_\_\_\_\_

Position/job title: \_\_\_\_\_ Type of industry: \_\_\_\_\_

Specify if you have worked in any of the following industries:

Industry	Yes	No	Years worked (e.g., 1990-1992)
Mine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Quarry	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foundry	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pottery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cotton, flax or hemp mill	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asbestos	<input type="checkbox"/>	<input type="checkbox"/>	_____

### PAST MEDICAL HISTORY - GENERAL

Do you consider yourself to be in good health?  Yes  No List specifics \_\_\_\_\_

Do you have any vision problems?  Yes  No \_\_\_\_\_

Do you have a hearing defect?  Yes  No \_\_\_\_\_

Are you suffering from or have you ever suffered from:

Epilepsy (seizures, convulsions)?  Yes  No \_\_\_\_\_

Rheumatic Fever?  Yes  No \_\_\_\_\_

Kidney Disease?  Yes  No \_\_\_\_\_

Bladder Disease?  Yes  No \_\_\_\_\_

Diabetes?  Yes  No \_\_\_\_\_

Jaundice?  Yes  No \_\_\_\_\_

## CHEST COLDS AND CHEST ILLNESSES

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

During the past three 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 any of these chest illnesses?       Yes     No

In the past three years, how many such illnesses with (increased) phlegm did you have which lasted a week or more?  
Number of illnesses: \_\_\_\_\_

Did you have any lung troubles before the age of 16?       Yes     No

**Have you ever had any of the following?**

	Yes	No		Yes	No	Age of first incidence
Attacks of bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	Confirmed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia (include bronchopneumonia)?	<input type="checkbox"/>	<input type="checkbox"/>	Confirmed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever?	<input type="checkbox"/>	<input type="checkbox"/>	Confirmed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	Confirmed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you still have it?	<input type="checkbox"/>	<input type="checkbox"/>				
Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	Confirmed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you still have it?	<input type="checkbox"/>	<input type="checkbox"/>				
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Confirmed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you still have it?	<input type="checkbox"/>	<input type="checkbox"/>				
If no longer have it, at what age did it stop?						_____
Any other chest illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please specify _____			
Any chest operations?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please specify _____			
Any chest injuries?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please specify _____			

Has any doctor ever told you that you have heart trouble?       Yes     No

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

Has any doctor ever told you that you have high blood pressure?       Yes     No

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

When did you have your last chest x-ray?    Year \_\_\_\_\_

Where did you have your last chest x-ray? \_\_\_\_\_

What the outcome of your last chest x-ray? \_\_\_\_\_

## COUGH

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1A. Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing of the throat). If <b>NO</b> , skip to question <b>1C</b> . | <input type="checkbox"/> | <input type="checkbox"/> |
| 1B. Do you usually cough as much as 4 to 6 times a day, 4 or more days out of the week?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 1C. Do you usually cough at all on getting up or first thing in the morning?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 1D. Do you usually cough at all during the rest of the day or at night?   | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered **YES** to any of the above questions, please answer the following two questions.

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1E. Do you usually cough like this on most days for 3 consecutive months or more during the year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 1F. For how many years have you had the cough? _____  |                          |                          |

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 2A. Do you usually bring up phlegm from your chest? (Count phlegm with the first smoke or on first going outdoors. Exclude phlegm from the nose. Count swallowed phlegm. If <b>NO</b> , skip to <b>2C</b> .) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2B. Do you usually bring up phlegm like this as much as twice a day, 4 or more days out of the week?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2C. Do you usually bring up phlegm at all on getting up or first thing in the morning?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2D. Do you usually bring up phlegm at all during the rest of the day or at night?  | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered **YES** to any of the above questions, please answer the following questions.

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 2E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2F. For how many years have you had trouble with phlegm? _____                                      |                          |                          |

## EPISODES OF COUGH AND PHLEGM

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year?<br>* (for persons who usually have cough and/or phlegm) | <input type="checkbox"/> | <input type="checkbox"/> |

If **YES**, how long have you had at least 1 such episode per year? \_\_\_\_\_

## WHEEZING

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Does your chest ever sound wheezy or whistling: |                          |                          |
| When you have a cold?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Occasionally apart from colds?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Most days or nights?                            | <input type="checkbox"/> | <input type="checkbox"/> |

If **YES** to any of the above, how many years has this been present? \_\_\_\_\_

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Have you ever had an attack of wheezing that has made you feel short of breath? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

If **YES**, how old were you when you had your first such attack? \_\_\_\_\_

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Have you had two or more such episodes? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Have you ever required medicine or treatment for these attacks? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

## BREATHLESSNESS

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

Nature of condition: \_\_\_\_\_

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

- |  |                          |                          |
|--|--------------------------|--------------------------|
| If <b>YES</b> ,<br>Do you have to walk slower than people of your age on level ground because of breathlessness? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Do you ever have to stop for breath when walking at your own pace on level ground? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on level ground? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

## TOBACCO SMOKING

Have you ever smoked cigarettes? (**NO** means less than 20 packs of cigarettes or 12 ounces of tobacco in a lifetime or less than 1 cigarette a day for 1 year). If **NO**, then skip to Family History Section.

YES    NO  
   

If **YES**,

Do you now smoke cigarettes (as of one month ago)?    

How old were you when you first started smoking cigarettes on a regular basis? \_\_\_\_\_

If you have stopped smoking cigarettes completely, how long were you when you stopped? \_\_\_\_\_

How many cigarettes do you smoke per day **NOW**? \_\_\_\_\_

In the entire time that you have been smoking, what is the average number of cigarettes you have smoked per day? \_\_\_\_\_

Do you or did you inhale the cigarette smoke?  Not at all     Slightly     Moderately     Deeply

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Have you ever smoked a pipe regularly? (**YES** means more than 12 oz. of tobacco in a lifetime)

YES    NO  
   

If **YES**,

How old were you when you started to smoke a pipe regularly? \_\_\_\_\_

If you have stopped smoking a pipe completely, how long were you when you stopped? \_\_\_\_\_

In the entire time that you have been smoking pipes, what is the average amount of pipe tobacco that you smoked in a week? (A standard pouch of pipe tobacco contains 1 ½ ounces). \_\_\_\_\_ oz. per week

How much pipe tobacco are you smoking now? \_\_\_\_\_ oz. per week

Do you or did you inhale the pipe smoke?  Not at all     Slightly     Moderately     Deeply

---

Have you ever smoked cigars regularly (YES means more than 1 cigar a week for a year).

YES    NO  
   

If **YES**,

How old were you when you started to smoke cigars regularly? \_\_\_\_\_

If you have stopped smoking cigars completely, how old were you when you stopped? \_\_\_\_\_

In the entire time that you have smoked cigars, what is the average number of cigars you have smoked per week? \_\_\_\_\_

How many cigars are you currently smoking per week? \_\_\_\_\_

Do you or did you inhale the cigar smoke?  Not at all     Slightly     Moderately     Deeply

**FAMILY HISTORY**

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

	<b>FATHER</b>	<b>MOTHER</b>
Chronic Bronchitis?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
Emphysema?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
Asthma?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
Lung Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
Other chest conditions?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
Is parent currently alive?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
Please specify:	Age if living: _____ Age at death: _____ Cause of death: _____	Age if living: _____ Age at death: _____ Cause of death: _____

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Interviewer Signature: \_\_\_\_\_

Date: \_\_\_\_\_