



**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

OSHA PERIODIC ASBESTOS MEDICAL QUESTIONNAIRE

Name:	SS#:	Clock #:
Present Occupation:	Employer:	
Employer Address:		
City:	State:	Zip:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated/Divorced		

OCCUPATIONAL HISTORY

In the past year, did you work full time (30 hours per week or more) for 6 months or more?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, how long?	
In the past year, did you work in a dusty job?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
If Yes, was dust exposure: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
In the past year, were you exposed to gas or chemical fumes in your work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, was exposure: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
In the past year, what was your: 1) Job/Occupation:	2) Position/Job Title:

RECENT MEDICAL HISTORY

Do you consider yourself to be in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, state reason:	
In the past year, have you developed (check all that apply):	
<input type="checkbox"/> Epilepsy <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Diabetes <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Jaundice <input type="checkbox"/> Bladder Disease <input type="checkbox"/> Cancer	

CHEST COLDS AND CHEST ILLNESSES

If you get a cold, does it usually go to your chest? (Usually means more than 1/2 the time)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't get colds
During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
Did you produce phlegm with any of these illnesses?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more?	
Number of illnesses _____ <input type="checkbox"/> No such illnesses	

RESPIRATORY SYSTEM

	Further Comment on Positive Answers
In the past year have you had:	
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chest Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Lung Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have:	
Frequent colds <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic cough <input type="checkbox"/> Yes <input type="checkbox"/> No	
Shortness of breath when walking or climbing one flight of stairs <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you:	
Wheeze <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cough up phlegm <input type="checkbox"/> Yes <input type="checkbox"/> No	
Smoke cigarettes <input type="checkbox"/> Yes <input type="checkbox"/> No	How many packs per day _____ How many years _____

Signature: _____

Date: _____

Interviewer: _____

Date: _____

Physical Examination

(To be completed by the examiner)

Name: _____ Date: _____

Ht: _____ Wt: _____

BP: _____ Pulse: _____

Repeat BP: _____ Exercise Pulse: _____

Without glasses	Both: _____ Far Rt: _____ Far Lt: _____
With glasses or contacts	Both: _____ Far Rt: _____ Far Lt: _____
Color Vision	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Test Type:	<input type="checkbox"/> Able to distinguish red/amber/green
	<input type="checkbox"/> Ishihara <input type="checkbox"/> Titmus
Peripheral vision	Rt: _____ Lt: _____

URINE MULTISTIX		
Test	Normal Range	Results
Glucose	<i>Negative</i>	
Bilirubin	<i>Negative</i>	
Ketone	<i>Negative</i>	
Specific Gravity	<i>1.001 - 1.030</i>	
Blood	<i>Negative</i>	
pH	<i>5-9</i>	
Protein	<i>Negative - Trace</i>	
Urobilinogen	<i>0.2 - 1.0 mg/dL</i>	
Nitrites	<i>Negative</i>	
Leukocytes	<i>Negative</i>	

	NORMAL	ABNORMAL	COMMENTS
General Appearance			
Skin			
HEENT			
Neck			
Lungs			
Heart			
Vascular			
Abdomen			
Inguinal/genitalia			
Extremities			
Spine			
Curvature			
Range of Motion			
Straight Leg Raising			
Gait			
Neurological			
Psychological			

- Normal
- Abnormal findings: _____
- _____
- Medical restrictions: _____
- _____

Examiner Signature: _____ Date: _____