

**ASBESTOS EXPOSURE
PART II - PERIODIC MEDICAL QUESTIONNAIRE**

IDENTIFICATION

1. NAME (Last, First, Middle Initial)	2. SOCIAL SECURITY NO. (1 - 9)	3. CLOCK NO. (10 - 15)	4. PRESENT OCCUPATION				
5. NAME OF PLANT	6. STREET ADDRESS OF PLANT		7. PLANT CITY, STATE AND ZIP CODE				
8. TELEPHONE NO. (Include area code)	9. NAME OF INTERVIEWER	10. DATE OF INTERVIEW (16 - 21) (YYYYMMDD)	11. MARITAL STATUS (X one) <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 50%; text-align: center;">a. SINGLE</td> <td style="border: 1px solid black; width: 50%; text-align: center;">b. MARRIED</td> </tr> <tr> <td style="border: 1px solid black; text-align: center;">c. WIDOWED</td> <td style="border: 1px solid black; text-align: center;">d. DIVORCED/SEPARATED</td> </tr> </table>	a. SINGLE	b. MARRIED	c. WIDOWED	d. DIVORCED/SEPARATED
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MEDICAL DATA

12. OCCUPATIONAL HISTORY	Yes	No	N/A	17. REMARKS (*Use this section to further comment on positive answers)
a. IN THE PAST YEAR, DID YOU WORK FULL TIME (30 hours per week or more) FOR SIX MONTHS OR MORE?				
b. DID YOU WORK AT ANY DUSTY JOB DURING THE PAST YEAR? *If Yes, complete c.				
c. WAS EXPOSURE (X one)				
MILD				
MODERATE				
SEVERE				
d. IN THE PAST YEAR, WERE YOU EXPOSED TO GAS OR CHEMICAL FUMES IN YOUR WORK? *If Yes, complete e.				
e. WAS EXPOSURE (X one)				
MILD				
MODERATE				
SEVERE				
f. IN THE PAST YEAR, WHAT WAS YOUR				
(1) Job/Occupation				
(2) Position/Job Title				
13. MEDICAL HISTORY	Yes	No	N/A	
a. DO YOU CONSIDER YOURSELF TO BE IN GOOD HEALTH? *If No, state reason.				
b. IN THE PAST YEAR, HAVE YOU DEVELOPED				
(1) Epilepsy (Or fits, seizures or convulsions)				
(2) Rheumatic Fever				
(3) Kidney Disease				
(4) Bladder Disease				
(5) Diabetes				
(6) Jaundice				
(7) Cancer				
14. IF YOU GET A COLD, DOES IT USUALLY GO TO YOUR CHEST? (Usually means more than 1/2 of the time)*Don't get colds			*	
15. CHEST ILLNESSES				
a. DURING THE PAST YEAR, HAVE YOU HAD ANY CHEST ILLNESSES THAT HAVE KEPT YOU OFF WORK, INDOORS AT HOME, OR IN BED?				
b. IF YES, DID YOU PRODUCE PHLEGM WITH ANY OF THESE ILLNESSES?				
c. IN THE LAST YEAR, HOW MANY SUCH ILLNESSES WITH INCREASED PHLEGM DID YOU HAVE WHICH LASTED A WEEK OR MORE? (List number)				
16. RESPIRATORY SYSTEM				
a. IN THE PAST YEAR, HAVE YOU HAD	*			
Yes	No			
b. DO YOU HAVE	Yes	*	No	
(1) Frequent Colds				
(2) Chronic Cough				
(3) Shortness of breath when walking or climbing one flight of stairs				
c. DO YOU				
(1) Wheeze				
(2) Cough up phlegm				
(3) Smoke cigarettes (If yes:)				
Packs per day				
Number of years				
18. SIGNATURE				
19. DATE SIGNED (YYYYMMDD)				