

**GULF REGIONAL OCCUPATIONAL MEDICINE CENTER**

**BATON ROUGE LOCATION:**

8742 Goodwood Blvd.  
Baton Rouge, LA 70806  
Phone #: 225-231-7070  
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**ABBEVILLE LOCATION:**

121 East St. Victor St.  
Abbeville, LA 70510  
Phone #: 337-893-0810  
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**INITIAL MEDICAL QUESTIONNAIRE FOR ASBESTOS WORKERS**

1. Name: \_\_\_\_\_ 2. S.S. #: \_\_\_\_\_

3. Employee No(ID): \_\_\_\_\_ 4. Present Occupation: \_\_\_\_\_

5. Employer / Plant: \_\_\_\_\_ 6. Address: \_\_\_\_\_

7. Interviewer: \_\_\_\_\_ 8. Date: \_\_\_\_\_

9. Date of birth: \_\_\_\_\_ 10. Place of birth: \_\_\_\_\_

(Please Circle)

11. Sex: M / F      12. Marital Status:      Single      Married      Separated      Divorced      Widowed

13. Race:      White      Black      Asian      Hispanic      American Native      Other: \_\_\_\_\_

14. What is the highest grade completed in school? \_\_\_\_\_

**OCCUPACIONAL HISTORY:**

15. A. Have you ever worked full-time (30 or more hours/week) for 6 months or more?      YES      NO  
     

If yes continue

B. Have you ever worked for a year or more in any dusty job?           

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

Was dust exposure:      Mild: \_\_\_\_\_      Moderate: \_\_\_\_\_      Severe: \_\_\_\_\_

C. Have you ever been exposed to gas or chemical fumes in your work?           

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

Was dust exposure:      Mild: \_\_\_\_\_      Moderate: \_\_\_\_\_      Severe: \_\_\_\_\_

D. What has been your usual occupation/job...the one you have worked at the longest?

1. Job/Occupation: \_\_\_\_\_

2. Number of years employed in this occupation: \_\_\_\_\_

3. Position or job title: \_\_\_\_\_

4. Business, field or industry: \_\_\_\_\_

Please, record on line the years in which you have in any of these following industries.(e.g., 1980-1989)

E. In a mine?      YES      NO  
     

In a quarry?           

In a foundry?           

In a pottery?           

In a cotton, flax or hemp mill?           

With asbestos?

**PAST MEDICAL HISTORY:**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 16. A. Do you consider yourself in good health?       | <input type="checkbox"/> | <input type="checkbox"/> |
| If "NO" state reason: _____                           |                          |                          |
| B. Do you have any vision defects?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| If "YES" state nature of your defect: _____           |                          |                          |
| C. Do you have any hearing defects?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| If "YES" state nature of your defect: _____           |                          |                          |
| D. Are you suffering from or have ever suffered from: |                          |                          |
| a. Epilepsy (or fits, seizures, convulsions)?         | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Rheumatic fever?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Kidney disease?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Bladder disease?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Diabetes?  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Jaundice?  | <input type="checkbox"/> | <input type="checkbox"/> |

**CHEST COLDS AND CHEST ILLNESS:**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 17. A. If you get a cold, does it <u>usually</u> (more than 1/2 the time)go to your chest?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. A. During the past 3 years, have you had any chest illness that has kept you from work, indoors at home, or in bed? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "YES" to continue  |                          |                          |
| B. Did you produce phlegm with any of these chest illnesses?  | <input type="checkbox"/> | <input type="checkbox"/> |
| C. In the last 3 years, how many chest illnesses with (increased) phlegm did you have which lasted a week or longer?    |                          |                          |
| Number of illnesses _____   |                          |                          |
| No such illnesses _____   |                          |                          |
| 19. Did you have any lung trouble before the age of 16?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever had any of the following?   |                          |                          |
| 1A. Attack of bronchitis?   | <input type="checkbox"/> | <input type="checkbox"/> |
| If "YES" please continue  |                          |                          |
| B. Was it confirmed by a doctor?  | <input type="checkbox"/> | <input type="checkbox"/> |
| C. At what age was your first attack?   | Age in Years _____       |                          |
| 2A. Pneumonia (including bronchopneumonia)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| IF "YES" please continue  |                          |                          |
| B. Was it confirmed by a doctor?  | <input type="checkbox"/> | <input type="checkbox"/> |
| C. At what age was your first attack?   | Age in Years _____       |                          |
| 3 A. Hay Fever?   | <input type="checkbox"/> | <input type="checkbox"/> |
| IF "YES" please continue  |                          |                          |
| B. Was it confirmed by a doctor?  | <input type="checkbox"/> | <input type="checkbox"/> |
| C. At what age was your first attack?   | Age in Years _____       |                          |
| 21. A. Have you ever had chronic bronchitis?  | <input type="checkbox"/> | <input type="checkbox"/> |
| If "YES" please continue  |                          |                          |
| B. Do you still have it?  | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Was it confirmed by a doctor?  | <input type="checkbox"/> | <input type="checkbox"/> |
| D. At what age did it start?  | Age in Years _____       |                          |
| 22. A. Have you ever had emphysema?   | <input type="checkbox"/> | <input type="checkbox"/> |
| If "YES" please continue  |                          |                          |
| B. Do you still have it?  | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Was it confirmed by a doctor?  | <input type="checkbox"/> | <input type="checkbox"/> |
| D. At what age did it start?  | Age in Years _____       |                          |

YES NO



- E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?  YES  NO
- F. For how many years have you had trouble with phlegm?  
Number of Years: \_\_\_\_\_

**EPISODES OF COUGH AND PHLEGM:**

32. A. Have you had periods or episodes of increased\* cough or phlegm lasting for 3 weeks?  
(\* meaning for persons who usually have cough and/or phlegm)  YES  NO
- B. For how long have you had at least 1 such episode per year?  
Number of Years: \_\_\_\_\_

**WHEEZING:**

33. A. Does your chest ever sound wheezy or whistling?  YES  NO
1. When you have a cold?  YES  NO
  2. Occasionally apart from colds?  YES  NO
  3. Most days or nights?  YES  NO
- If "YES" please continue
- B. For how many years has this been present?  
Number of Years: \_\_\_\_\_
34. A. Have you ever had an attack of wheezing that has made you feel short of breath?  YES  NO
- B. How old were you when you had your first such attack?  YES  NO
  - C. Have you had 2 or more such episodes?  YES  NO
  - D. Have you ever required medicine or treatment for these attacks?  YES  NO

**BREATHLESSNESS:**

35. If disabled from walking by conditions other than heart or lung disease, please describe and proceed to question 37A. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

36. A. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?  YES  NO
- If "YES" please continue
- B. Do you have to walk slower than people of your age on level ground because of breathlessness?  YES  NO
  - C. Do you ever have to stop for breath when walking at your own pace on level ground?  YES  NO
  - D. Do you ever have to stop for a breath after walking about 100 yards (after a few minutes) on level ground?  YES  NO
  - E. are you too breathless to leave the house or breathless after dressing, or climbing one flight of stairs?  YES  NO

**TOBACCO SMOKING:**

37. A. Have you ever smoked cigarettes?  YES  NO
- (NO means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime)
- If "YES" please continue
- B. Do you now smoke cigarettes (as of 1 month ago)?  YES  NO
  - C. How old were you when you first started regular cigarette smoking?  
Age in Years: \_\_\_\_\_
  - D. If you have stopped smoking completely, how old were you when you stopped?  
Age in Years: \_\_\_\_\_
  - E. How many cigarettes do you smoke per day now?  
Cigarettes a Day: \_\_\_\_\_

F. On the average of the entire time you smoked, how many cigarettes did you smoke per day?

Cigarettes a Day: \_\_\_\_\_

G. Do or did you inhale the cigarette smoke?

Slightly       Moderately       Deeply

    

38. A. Have you ever smoked a pipe regularly?

(YES means more than 12 oz. of tobacco in a lifetime)

    

B. 1. How old were you when you started to smoke a pipe regularly?

Age in Years: \_\_\_\_\_

2. If you have stopped smoking a pipe completely, how old were you when you stopped?

Age in Years: \_\_\_\_\_

C. On the average over the entire time you smokes a pipe, how much tobacco did you smoke per week?

(a standard pouch contains 1 1/2 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?

Slightly       Moderately       Deeply

    

39. A. Have you ever smoked cigars regularly?

(YES means more than 1 cigar a week for a year)

    

FOR PERSONS WHO HAVE EVER SMOKED CIGARS:

B. 1. How old were you when you started smoking cigars regularly?

Age in Years: \_\_\_\_\_

2. If you have stopped smoking cigars completely, how old were you when you stopped?

Age in Years: \_\_\_\_\_

C. On the average over the entire time you smoked cigars, how many cigars did you smoke?

Cigars a Week: \_\_\_\_\_

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

Cigars a Week: \_\_\_\_\_

E. Do or did you inhale the cigar smoke?

Slightly       Moderately       Deeply

    

**Signature:** \_\_\_\_\_

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