ASBESTOS EXPOSURE
PART I - INITIAL 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. DATE OF BIRTH *(22 - 29) (YYYYMMDD)*	12. PLACE OF BIRTH

13. SEX *(X one)*	14. MARITAL STATUS *(X one)*	15. RACE *(X one)*	16. HIGHEST GRADE COMPLETED IN SCHOOL
☐ a. MALE ☐ b. FEMALE	☐ a. SINGLE ☐ b. MARRIED ☐ c. WIDOWED ☐ d. DIVORCED/SEPARATED	☐ a. WHITE ☐ b. BLACK ☐ c. ASIAN ☐ d. HISPANIC ☐ e. INDIAN ☐ f. OTHER	

MEDICAL DATA

17. OCCUPATIONAL HISTORY	Yes	No	N/A
a. HAVE YOU EVER WORKED FULL TIME *(30 hours per week or more)* FOR SIX MONTHS OR MORE?			
b. IF YES, HAVE YOU EVER WORKED FOR A YEAR OR MORE IN ANY DUSTY JOB? **If Yes, complete (1) - (3).*	*		
(1) Specify Job/Industry — (2) Total years worked — (3) Dust Exposure *(X one)*: ☐ MILD ☐ MODERATE ☐ SEVERE			
c. HAVE YOU EVER BEEN EXPOSED TO GAS OR CHEMICAL FUMES IN YOUR WORK? **If Yes, complete (1) - (3).*	*		
(1) Specify Job/ Industry — (2) Total years worked — (3) Exposure *(X one)*: ☐ MILD ☐ MODERATE ☐ SEVERE			
d. WHAT HAS BEEN YOUR USUAL OCCUPATION - THE ONE YOU HAVE WORKED AT THE LONGEST?			
(1) Job/Occupation — (2) Number of years employed in this occupation			
(3) Position/Job Title — (4) Business, Field or Industry			
e. HAVE YOU EVER WORKED *(X Yes or No and specify years worked, e.g. 1960 - 1969.)* — Years Worked			
(1) In a mine			
(2) In a quarry			
(3) In a foundry			
(4) In a pottery			
(5) In a cotton, flax or hemp mill			
(6) With asbestos			
18. MEDICAL HISTORY			
a. DO YOU CONSIDER YOURSELF TO BE IN GOOD HEALTH? **If No, state reason.*	*		
b. HAVE YOU ANY DEFECT OF VISION? **If Yes, state nature of defect.*	*		
c. HAVE YOU ANY HEARING DEFECT? **If Yes, state nature of defect.*	*		
d. ARE YOU SUFFERING FROM OR HAVE YOU EVER SUFFERED FROM			
(1) Epilepsy *(Or fits, seizures or convulsions)*			
(2) Rheumatic Fever			
(3) Kidney Disease			
(4) Bladder Disease			
(5) Diabetes			
(6) Jaundice			
19. 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*			*
20. CHEST ILLNESSES			
a. DURING THE PAST THREE YEARS, 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 THREE YEARS, HOW MANY SUCH ILLNESSES WITH INCREASED PHLEGM DID YOU HAVE WHICH LASTED A WEEK OR MORE? *(List number)*			

21. DID YOU HAVE ANY LUNG TROUBLE BEFORE THE AGE OF 16?	Yes	No	N/A
22. HAVE YOU EVER HAD ANY OF THE FOLLOWING?			
a. ATTACKS OF BRONCHITIS ** If yes, complete (1) and (2).*	*		
(1) Age at first attack — (2) Was it confirmed by a doctor?			
b. ATTACKS OF PNEUMONIA *(Include bronchopneumonia) *If yes, complete (1) and (2)*	*		
(1) Age at first attack — (2) Was it confirmed by a doctor?			
c. HAY FEVER ** If yes, complete (1) and (2).*	*		
(1) Age at first attack — (2) Was it confirmed by a doctor?			
23. HAVE YOU EVER HAD CHRONIC BRONCHITIS?			
a. IF YES, DO YOU STILL HAVE IT?			
b. WAS IT CONFIRMED BY A DOCTOR?			
c. AT WHAT AGE DID IT START? *(List age)*			
24. HAVE YOU EVER HAD EMPHYSEMA?			
a. IF YES, DO YOU STILL HAVE IT?			
b. WAS IT CONFIRMED BY A DOCTOR?			
c. AT WHAT AGE DID IT START? *(List age)*			
25. HAVE YOU EVER HAD ASTHMA?			
a. IF YES, DO YOU STILL HAVE IT?			
b. WAS IT CONFIRMED BY A DOCTOR?			
c. AT WHAT AGE DID IT START? *(List age)*			
d. IF YOU NO LONGER HAVE IT, AT WHAT AGE DID IT STOP? *(List age)*			
26. HAVE YOU EVER HAD:			
a. ANY OTHER CHEST ILLNESSES **If yes, please specify.*	*		
b. ANY CHEST OPERATIONS **If yes, please specify.*	*		
c. ANY CHEST INJURIES **If yes, please specify.*	*		
27. HEART TROUBLE			
a. HAS A DOCTOR EVER TOLD YOU THAT YOU HAD HEART TROUBLE?			
b. IF YES, HAVE YOU EVER HAD TREATMENT FOR HEART TROUBLE IN THE PAST TEN YEARS?			
28. HIGH BLOOD PRESSURE			
a. HAS A DOCTOR EVER TOLD YOU THAT YOU HAD HIGH BLOOD PRESSURE *(Hypertension)?*			
b. IF YES, HAVE YOU EVER HAD TREATMENT FOR HIGH BLOOD PRESSURE IN THE PAST TEN YEARS?			
29. WHEN DID YOU LAST HAVE YOUR CHEST X-RAYED? *(Year)*			
30. CHEST X-RAY			
a. WHERE DID YOU LAST HAVE YOUR CHEST X-RAYED? *(If known)*			
b. WHAT WAS THE OUTCOME?			

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MEDICAL DATA *(Continued)*

31. WERE EITHER OF YOUR NATURAL PARENTS TOLD THAT THEY HAD A CHRONIC LUNG CONDITION SUCH AS	Father Yes	Father No	Father Don't Know	Mother Yes	Mother No	Mother Don't Know
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 AT DEATH						

CAUSE OF DEATH — Father: N/A — Mother: N/A

32. COUGH	Yes	No	N/A
a. DO YOU USUALLY HAVE A COUGH? *(Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.) *If No, skip to question 32.c.*		*	
b. DO YOU USUALLY COUGH AS MUCH AS FOUR TO SIX TIMES A DAY FOUR OR MORE DAYS OUT OF THE WEEK?			
c. DO YOU USUALLY COUGH AT ALL ON GETTING UP OR FIRST THING IN THE MORNING?			
d. DO YOU USUALLY COUGH AT ALL DURING THE REST OF THE DAY OR AT NIGHT?			
IF YES TO ANY OF ABOVE (32.a., b., c., or d.), ANSWER THE FOLLOWING. IF NO TO ALL, X "N/A" AND SKIP TO ITEM 33.			
e. DO YOU USUALLY COUGH LIKE THIS ON MOST DAYS FOR THREE CONSECUTIVE MONTHS OR MORE DURING THE YEAR?			
f. FOR HOW MANY YEARS HAVE YOU HAD THE COUGH?			

33. PHLEGM	Yes	No	N/A
a. 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.) *If No, skip to Item 33.c.*		*	
b. DO YOU USUALLY BRING UP PHLEGM LIKE THIS AS MUCH AS TWICE A DAY FOUR OR MORE DAYS OUT OF THE WEEK?			
c. DO YOU USUALLY BRING UP PHLEGM AT ALL ON GETTING UP OR FIRST THING IN THE MORNING?			
d. DO YOU USUALLY BRING UP PHLEGM AT ALL DURING THE REST OF THE DAY OR AT NIGHT?			
IF YES TO ANY OF ABOVE (33.a., b., c., or d.), ANSWER THE FOLLOWING. IF NO TO ALL, X "N/A" AND SKIP TO ITEM 34.			
e. DO YOU USUALLY BRING UP PHLEGM LIKE THIS ON MOST DAYS FOR THREE CONSECUTIVE MONTHS OR MORE DURING THE YEAR?			
f. FOR HOW MANY YEARS HAVE YOU HAD TROUBLE WITH PHLEGM?			

34. EPISODES OF COUGH AND PHLEGM	Yes	No	N/A
a. HAVE YOU HAD PERIODS OR EPISODES OF *(increased*)* COUGH AND PHLEGM LASTING FOR THREE WEEKS OR MORE EACH YEAR? **For persons who usually have cough and/or phlegm*			
b. FOR HOW LONG HAVE YOU HAD AT LEAST ONE SUCH EPISODE PER YEAR? *(Number of years)*			

35. WHEEZING/WHISTLING	Yes	No	N/A
a. DOES YOUR CHEST EVER SOUND WHEEZY OR WHISTLING			
(1) When you have a cold			
(2) Occasionally apart from colds			
(3) Most days or nights			
b. IF YES TO 35.a.(1), (2) or (3), FOR HOW MANY YEARS HAS THIS BEEN PRESENT *(Number of years)*			

36. WHEEZING/SHORTNESS OF BREATH	Yes	No	N/A
a. HAVE YOU EVER HAD AN ATTACK OF WHEEZING THAT HAS MADE YOU FEEL SHORT OF BREATH?			
b. IF YES, HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST SUCH ATTACK? *(Number of years)*			
c. HAVE YOU HAD TWO OR MORE SUCH EPISODES?			
d. HAVE YOU EVER REQUIRED MEDICINE OR TREATMENT FOR THE(SE) ATTACKS?			

37. IF DISABLED FROM WALKING BY ANY CONDITION OTHER THAN HEART OR LUNG DISEASE, PLEASE DESCRIBE NATURE OF CONDITION(S) AND PROCEED TO QUESTION 39.a.

38. BREATHLESSNESS	Yes	No	N/A
a. ARE YOU TROUBLED BY SHORTNESS OF BREATH WHEN HURRYING ON THE LEVEL OR WALKING UP A SLIGHT HILL?			
b. IF YES, DO YOU HAVE TO WALK SLOWER THAN PEOPLE OF YOUR AGE ON THE LEVEL BECAUSE OF BREATHLESSNESS?			
c. DO YOU EVER HAVE TO STOP FOR BREATH WHEN WALKING AT YOUR OWN PACE ON THE LEVEL?			
d. DO YOU EVER HAVE TO STOP FOR BREATH AFTER WALKING ABOUT 100 YARDS *(or after a few minutes)* ON THE LEVEL?			
e. ARE YOU TOO BREATHLESS TO LEAVE THE HOUSE OR BREATHLESS ON DRESSING OR CLIMBING ONE FLIGHT OF STAIRS?			

39. CIGARETTE SMOKING	Yes	No	N/A
a. 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.*		*	
b. IF YES, DO YOU NOW SMOKE CIGARETTES? *(As of one month ago)?*			
c. HOW OLD WERE YOU WHEN YOU FIRST STARTED REGULAR CIGARETTE SMOKING? *(Number of years)*			
d. IF YOU HAVE STOPPED SMOKING CIGARETTES COMPLETELY, HOW OLD WERE YOU WHEN YOU STOPPED? *(List age in (1) or X (2))* (1) Age in years ☐ (2) Still smoking			
e. HOW MANY CIGARETTES DO YOU SMOKE PER DAY NOW?			
f. ON THE AVERAGE OF THE ENTIRE TIME YOU SMOKED, HOW MANY CIGARETTES DID YOU SMOKE PER DAY?			
g. DO OR DID YOU INHALE CIGARETTE SMOKE *(X one)* ☐ (1) Not at all ☐ (2) Slightly ☐ (3) Moderately ☐ (4) Deeply			

40. PIPE SMOKING	Yes	No	N/A
a. HAVE YOU EVER SMOKED A PIPE REGULARLY? **Yes means more than 12 oz. of tobacco in a lifetime.*	*		
b. HOW OLD WERE YOU WHEN YOU FIRST STARTED PIPE SMOKING? *(Number of years)*			
c. IF YOU HAVE STOPPED SMOKING A PIPE COMPLETELY, HOW OLD WERE YOU WHEN YOU STOPPED? *(List age in (1) or X (2))* (1) Age in years ☐ (2) Still smoking			
d. ON THE AVERAGE OF THE ENTIRE TIME YOU SMOKED, HOW MUCH PIPE TOBACCO DID YOU SMOKE PER WEEK? *(Oz. per week - a standard pouch of tobacco contains 1 1-1/2 oz.)*			
e. HOW MUCH PIPE TOBACCO DO YOU SMOKE PER WEEK NOW?			
f. DO OR DID YOU INHALE PIPE SMOKE *(X one)* ☐ (1) Not at all ☐ (2) Slightly ☐ (3) Moderately ☐ (4) Deeply			

41 CIGAR SMOKING	Yes	No	N/A
a. HAVE YOU EVER SMOKED CIGARS REGULARLY? **Yes means more than 1 cigar a week for a year.*	*		
b. HOW OLD WERE YOU WHEN YOU FIRST STARTED REGULAR CIGAR SMOKING? *(Number of years)*			
c. IF YOU HAVE STOPPED SMOKING CIGARS COMPLETELY, HOW OLD WERE YOU WHEN YOU STOPPED? *(List age in (1) or X (2))* (1) Age in years ☐ (2) Still smoking			
d. ON THE AVERAGE OF THE ENTIRE TIME YOU SMOKED, HOW MANY CIGARS DID YOU SMOKE PER WEEK?			
e. HOW MANY CIGARS DO YOU SMOKE PER WEEK NOW?			
f. DO OR DID YOU INHALE CIGAR SMOKE *(X one)* ☐ (1) Not at all ☐ (2) Slightly ☐ (3) Moderately ☐ (4) Deeply			

43. SIGNATURE

44. DATE SIGNED *(YYYYMMDD)*

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