Fermilab

Please complete this OSHA questionnaire and return it

Fermilab Occupational Medical Office – Mail Stop 204

ASBESTOS QUESTIONNAIRE (used for Asbestos and Grit Blasters)

Standard #: 1926.1101 App D

PERIODIC MEDICAL QUESTIONNAIRE

Part 2

Name: _____ ID# _____

Present Occupation: _____DOB:_____

Telephone Ext. :_____Date: _____

Occupational History

In the past year, did you work full time (30 hours per week or more) for 6 months or more:

Yes _____ No _____

In the past year, did you work in a dusty job?

Yes _____ No _____ Does not apply _____

Was dust exposure:

Mild _____ Moderate _____ Severe _____

In the past year, were you exposed to gas or chemical fumes in your work?

Yes _____ No _____

Was exposure:

Mild _____ Moderate _____ Severe _____

In the past year, what was your:

Job/Occupation? _____

Position/job title? _____

Recent Medical History

Do you consider yourself to be in good health?

Yes _____ No _____ If No, state reason: _____

In the past year, have you developed:

Epilepsy	Yes _____	No _____
Rheumatic Fever	Yes _____	No _____
Kidney Disease	Yes _____	No _____
Bladder Disease	Yes _____	No _____
Diabetes	Yes _____	No _____
Jaundice	Yes _____	No _____
Cancer	Yes _____	No _____

Chest Colds and Chest Illnesses

If you get a cold, does it "usually" go to your chest? (usually means more than ½ the time)

Yes _____ No _____ Does not apply _____

During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed:

Yes _____ No _____ Does not apply _____

Did you produce phlegm with any of these chest illnesses?

Yes _____ No _____ Does not apply _____

In the past year, how many such illness with (increased) phlegm did you have which lasted a week or more?

Number of illnesses _____ No such illnesses _____

Respiratory System

In the past year have you had:

Asthma	Yes _____	No _____
Bronchitis	Yes _____	No _____
Hey Fever	Yes _____	No _____
Other Allergies	Yes _____	No _____
Pneumonia	Yes _____	No _____
Tuberculosis	Yes _____	No _____

Further comment on positive answers: _____

_____

_____

Respiratory System – con't

In the past year have you had:

Chest Surgery Yes _____ No _____

Other Lung Problems Yes _____ No _____

Heart Disease Yes _____ No _____

Further comment on positive answers: _____

_____

_____

In the past year have you had:

Frequent Colds Yes _____ No _____

Chronic Cough Yes _____ No _____

Shortness of breath when walking or climbing one flight of stairs

Yes _____ No _____

Further comment on positive answers: _____

_____

_____

Do you:

Wheeze Yes _____ No _____

Cough up phlegm Yes _____ No _____

Smoke Cigarettes Yes _____ No _____ Packs per day _____ Years _____

Signature: _____Date: _____

Health Care Provider: _____Date: _____