Nevada Occupational HEALTH & INJURY CARE CENTER

Service Date:_____

Silica/Asbestos Medical Questionnaire

Patient Name: _____ SSN:_____

Address:_____City:_____St:_____Zip Code:_____
DOB:_____Gender: M / F

Marital Status: Single / Married/ Divorced/ Separated / Widow

Home Phone: _____Work Phone:_____

Race: Asian / Black / Hispanic / Indian / White / Other:

Occupational History:

Have you ever worked full time (30 hours per week or more) for six months or more? ___Yes __No

Have you ever worked for a year or more in any dusty job? ___Yes ___No

Specific job/industry_____Total years worked_____

Was exposure ____Mild ___Moderate ___Severe

What has been your usual occupation or job – the one you have worked on the longest?

1) Job occupation_____
2) Number of years employed in this occupation_____
3) Position/Job title_____
4) Business, field or industry_____

HAVE YOU EVER WORKED (record on "yes" lines the years in which you have worked in any of these industries, e.g. 1960-1969)

In a mine? _____Yes ___No

In a pottery? _____Yes ___No

In a quarry ? _____Yes ___No

In a cotton, flax, or hemp mill? _____Yes ___No

In a foundry? _____Yes ___No

With asbestos? _____Yes ___No

With Silica? _____Yes ___No

Past Medical History

Do you consider yourself to be in good health? ___Yes ___No

If "NO" state reason _____

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Have you any defect of vision? ___Yes ___No

If "YES" state nature of defect_____

Have you any hearing defect? ___Yes ___No

If "YES" state nature of defect_____

Are you suffering from or have you ever suffered from:

Epilepsy(or fits, seizures, convulsions)? ___Yes ___No Bladder Disease? ___Yes ___No

Rheumatic Fever? ___Yes ___No Diabetes? ___Yes ___No

Kidney Disease? ___Yes ___No Jaundice? ____Yes ___No

Tuberculosis? ___Yes ___No

Check all that apply to you:

	YES	**NO**	**Does Not Apply**
If you get a cold, does it usually go into your chest?			
During the past three years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?			
Did you produce phlegm with any of these chest illnesses?			
In the last three years, how many such illnesses with (increased) phlegm did you have which lasted a week or more?	_____# of illnesses	_____No such illnesses	
Did you have any lung trouble before the age of 18?			
Have you ever had bronchitis?			
Was your bronchitis confirmed by a doctor?			

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At what age did you first have bronchitis?	Age_____		
Do you have Hay Fever?			
Has a doctor confirmed your Hay Fever?			
At what age did your Hay Fever start?	Age_____		
Have you ever had Chronic Bronchitis?			
Do you still have it?			
Was it confirmed by a doctor?			
At what age did it start?	Age_____		
Have you ever had emphysema?			
Do you still have it?			
Was it confirmed by a doctor?			
At what age did it start?	AGE_____		
Have you ever had Asthma?			
Do you still have it?			
Was it confirmed by a doctor?			
At what age did it start?	Age_____		
If you no longer have it, at what age did it stop?	Age_____		
Have you ever had any other chest illness?			
If yes, please specify:_____			
Any chest operations:_____			
Any chest injuries:_____			
Have you been diagnosed with heart problems?			
Have you ever had treatment for heart trouble in the past ten years?			

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Has a doctor ever told you that you had high blood pressure?			
Have you had any treatment for high blood pressure in the past ten years?			
When did you last have your chest xrayed?	_____Year		
Where did youi last have your chest xrayed?	Facility_____		
What was the outcome?			

Family History

Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

Condition	Yes/Father	No/Father	Do Not Know	Yes/Mother	No/Mother	Do Not Know
Chronic Bronchitis						
Emphysema						
Asthma						
Lung Cancer						
Other chest conditions						
Is parent currently alive						
Age if Alive:	Age_____			Age_____		
Age if deceased		Age_____			Age_____	
Cause of death:				Cause of death:		

Cough

Do you usually have a cough? ____Yes ____No

Do you usually cough as much as four to six times a day four or more days out of the week? ____Yes ____No

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Do you usually cough at all on getting up or first thing in the morning? ____Yes ____No

Do you usually cough at all during the rest of the day or at night? ____Yes ____No

Do you usually cough like this on most days for three consecutive months or more during the year? ____Yes ____No

For how many years have you had the cough? ____# of years ___Does not apply

Do you usually bring up phlegm from your chest? ____Yes ____No

Do you usually bring up phlegm like this as much as twice a day four or more days out of the week? ____Yes ____No

Do you usually bring up phlegm at all on getting up or first thing in the morning? ____Yes ____No

Do you usually bring up phlegm at all during the rest of the day or at night? ____Yes ____No

Do you bring up phlegm like this on most days for three consecutive months Or more? ____Yes ____No

For how many years have you had trouble with phlegm? ____# of years ___Does not apply

Episodes of Cough and Phlegm

Have you had periods of (increased) cough and phlegm lasting for three weeks or more each year? ____Yes ____No

For how long have you had least one such episode per year? ____Yes ____No

Wheezing

Does your chest ever sound wheezy or whistling:

When you have a cold? ____Yes ____No

Occasionally apart from colds? ____Yes ____No

Most days or nights? ____Yes ____No

For how many years has this been present? ____# of years ____Does not apply

Have you ever had an attack of wheezing that has made you feel short of breath? ____Yes ____No

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How old were you when you had your first such attack? _____Age ____Does not apply

Have you had two or more such episodes? ____Yes ____No

Have you ever required medicine or treatment for the(se) attacks? ____Yes ____No

Breathlessness

If disabled from walking by any condition other than heart or lunch disease, please describe and proceed to Tobacco section.

Nature of condition(s):

_____

_____

Are you troubled by shortness o breath when hurrying on the level of walking up a slight hill? ____Yes ____No

Do you have to walk slower than people of our age on the level because of breathlessness? ____Yes ____No

Do you ever have to stop for a breath when walking at your own pace on the level? ____Yes ____No

Do you ever have to stop for a breath after walking about 100 yards (or after a few minutes) on the level? ____Yes ____No

Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs? ____Yes ____No

Tobacco Smoking

Have you ever smoked cigarettes? ____Yes ____No

Do you now smoke cigarettes (as of one month ago)? ____Yes ____No

How old were you when you started smoking regularly? ___Yes ____No

If you have stopped smoking cigarettes completely, how old were you when you stopped? ____Yes ____No

How many cigarettes do you smoke per day now? ____# per day ____Does not apply

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

Do or did you inhale the cigarette smoke? ____slightly ____moderately ____deeply ____not at all ____does not apply

Have you ever smoked a pipe regularly? ____Yes ____No

How old were you when you started to smoke a pipe regularly? ____Yes ____No

If you have stopped smoking a pipe completely, how old were you

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when you stopped? ____Age ____Does not apply
On the average over the entire time you smoked a pipe,
How much pipe tobacco did you smoke per week? ____Ounces per week
____Does not apply
How much pipe tobacco are you smoking now? ____Ounces per week
____Does not apply
Do you or did you inhale the pipe smoke? ____slightly ____moderately
____deeply ____not at all

Have you ever smoked cigars regularly? ____Yes ____No

How old were you when you started to smoke
cigars regularly? ____Age ____Does not apply
If you have stopped smoking cigars completely,
how old were you when you stopped? ____Age ____Does not apply
On the average over the entire time you smoked cigars,
how many cigars did you smoke per week? ____# per week ____Does not apply
How many cigars are you smoking now? ____# per week ____Does not apply
Do you or did you inhale the cigar smoke? ____slightly ____moderately
____deeply ____not at all

Tuberculosis

Have you had a TB skin test before? ____Yes ____No

Have you ever had a "positive" TB skin test? ____Yes ____No

Have you ever been treated for tuberculosis? ____Yes ____No

Have you ever received the BCG Vaccine?
(Given outside of the United States which may lead to false positive) ____Yes ____No

Have you ever experience any ulceration or open weeping
sores due to TB injection? ____Yes ____No

Do you have any of the following symptoms?
____Cough lasting more than 3 weeks ____Night Sweats ___Loss of appetite
____Bloody sputum ____Weight loss ___Fever ____None of these

_____ _____

Signature *Date*