Appendix D to §1926.1101
Periodic Medical Questionnaires - Mandatory

Part 2

PERIODIC MEDICAL QUESTIONNAIRE:

1. NAME:
3. CLOCK NUMBER: _____
4. PRESENT OCCUPATION: _____
5. PLANT: _____
6. ADDRESS: _____
7. CITY: _____ ST: ____ ZIP CODE: _____
8. TELEPHONE NUMBER: (_____) _____ - _____ EXT. _____
9. INTERVIEWER: _____
10. DATE: ____ / ____ / ____
11. What is your marital status? 1. ☐ Single 2. ☐ Married 3. ☐ Widowed 4. ☐ Separated/Divorced

12. OCCUPATIONAL HISTORY

12A. In the past year, did you work full time (30 hours per week or more) for 6 months or more? 1. ☐ Yes 2. ☐ No

IF YES TO 12A:

12B. In the past year, did you work in a dusty job? 1. ☐ Yes 2. ☐ No 3. ☐ Does Not Apply

12C. Was dust exposure: 1. ☐ Mild 2. ☐ Moderate 3. ☐ Severe

12D. In the past year, were you exposed to gas or chemical fumes in your work? 1. ☐ Yes 2. ☐ No

12E. Was exposure: 1. ☐ Mild 2. ☐ Moderate 3. ☐ Severe

12F. In the past year, what was your:

1. Job/Occupation? _____
2. Position/Job Title? _____

13. RECENT MEDICAL HISTORY

13A. Do you consider yourself to be in good health? 1. ☐ Yes 2. ☐ No

If "No", state reason: _____

13B. 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

14. CHEST COLDS AND CHEST ILLNESSES

14A. If you get a cold, does it "usually" go to your chest? (Usually means more than 1/2 the time) 1. ☐ Yes 2. ☐ No 3. ☐ Don't Get Colds

15A. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? 1. ☐ Yes 2. ☐ No 3. ☐ Does Not Apply

IF YES TO 15A:

15B. Did you produce phlegm with any of these chest illnesses? 1. ☐ Yes 2. ☐ No 3. ☐ Does Not Apply

15C. In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more? ____ Number of Illnesses ☐ No Such Illnesses

16. RESPIRATORY SYSTEM

In the past year have you had:			Further Comment on Positive Answers
Asthma	☐ Yes	☐ No	_____
Bronchitis	☐ Yes	☐ No	_____
Hay Fever	☐ Yes	☐ No	_____
Other Allergies	☐ Yes	☐ No	_____
Pneumonia	☐ Yes	☐ No	_____
Tuberculosis	☐ Yes	☐ No	_____
Chest Surgery	☐ Yes	☐ No	_____
Other Lung Problems	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
Do You Have:			
Frequent Colds	☐ Yes	☐ No	_____
Chronic Cough	☐ Yes	☐ No	_____
Shortness of Breath When Walking or Climbing One Flight of Stairs	☐ Yes	☐ No	_____
Do you:			
Wheeze	☐ Yes	☐ No	_____
Cough Up Phlegm	☐ Yes	☐ No	_____
Smoke Cigarettes	☐ Yes	☐ No	____ Packs Per Day ____ How Many Years

_____ Date: ____ / ____ / ____

Signature