

**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. <i>(Include area code)</i>		9. NAME OF INTERVIEWER		10. DATE OF INTERVIEW <i>(16 - 21) (YYYYMMDD)</i>		11. DATE OF BIRTH <i>(22 - 29) (YYYYMMDD)</i>		
13. SEX <i>(X one)</i>		14. MARITAL STATUS <i>(X one)</i>			15. RACE <i>(X one)</i>			16. HIGHEST GRADE COMPLETED IN SCHOOL
<input type="checkbox"/> a. MALE <input type="checkbox"/> b. FEMALE		<input type="checkbox"/> a. SINGLE <input type="checkbox"/> b. MARRIED <input type="checkbox"/> c. WIDOWED <input type="checkbox"/> d. DIVORCED/SEPARATED			<input type="checkbox"/> a. WHITE <input type="checkbox"/> b. BLACK <input type="checkbox"/> c. ASIAN <input type="checkbox"/> d. HISPANIC <input type="checkbox"/> e. INDIAN <input type="checkbox"/> f. OTHER			

**MEDICAL DATA**

17. OCCUPATIONAL HISTORY				Yes	No	N/A	21. DID YOU HAVE ANY LUNG TROUBLE BEFORE THE AGE OF 16?				Yes	No	N/A
a. HAVE YOU EVER WORKED FULL TIME (30 hours per week or more) FOR SIX MONTHS OR MORE?							22. HAVE YOU EVER HAD ANY OF THE FOLLOWING?						
b. IF YES, HAVE YOU EVER WORKED FOR A YEAR OR MORE IN ANY DUSTY JOB? *If Yes, complete (1) - (3).							a. ATTACKS OF BRONCHITIS * If yes, complete (1) and (2).						
(1) Specify Job/Industry		(2) Total years worked	(3) Dust Exposure <i>(X one)</i>				(1) Age at first attack		(2) Was it confirmed by a doctor?				
			<input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE				b. ATTACKS OF PNEUMONIA (Include bronchopneumonia) *If yes, complete (1) and (2)						
c. HAVE YOU EVER BEEN EXPOSED TO GAS OR CHEMICAL FUMES IN YOUR WORK? *If Yes, complete (1) - (3).							(1) Age at first attack		(2) Was it confirmed by a doctor?				
(1) Specify Job/ Industry		(2) Total years worked	(3) Exposure <i>(X one)</i>				c. HAY FEVER * If yes, complete (1) and (2).						
			<input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE				(1) Age at first attack		(2) Was it confirmed by a doctor?				
d. WHAT HAS BEEN YOUR USUAL OCCUPATION - THE ONE YOU HAVE WORKED AT THE LONGEST?							23. HAVE YOU EVER HAD CHRONIC BRONCHITIS?						
(1) Job/Occupation		(2) Number of years employed in this occupation					a. IF YES, DO YOU STILL HAVE IT?						
(3) Position/Job Title		(4) Business, Field or Industry					b. WAS IT CONFIRMED BY A DOCTOR?						
e. HAVE YOU EVER WORKED <i>(X Yes or No and specify years worked, e.g. 1960 - 1969.)</i>							c. AT WHAT AGE DID IT START? (List age)						
(1) In a mine		Years Worked					24. HAVE YOU EVER HAD EMPHYSEMA?						
(2) In a quarry							a. IF YES, DO YOU STILL HAVE IT?						
(3) In a foundry							b. WAS IT CONFIRMED BY A DOCTOR?						
(4) In a pottery							c. AT WHAT AGE DID IT START? (List age)						
(5) In a cotton, flax or hemp mill							25. HAVE YOU EVER HAD ASTHMA?						
(6) With asbestos							a. IF YES, DO YOU STILL HAVE IT?						
18. MEDICAL HISTORY							b. WAS IT CONFIRMED BY A DOCTOR?						
a. DO YOU CONSIDER YOURSELF TO BE IN GOOD HEALTH? *If No, state reason.							c. AT WHAT AGE DID IT START? (List age)						
b. HAVE YOU ANY DEFECT OF VISION? *If Yes, state nature of defect.							d. IF YOU NO LONGER HAVE IT, AT WHAT AGE DID IT STOP? (List age)						
c. HAVE YOU ANY HEARING DEFECT? *If Yes, state nature of defect.							26. HAVE YOU EVER HAD:						
d. ARE YOU SUFFERING FROM OR HAVE YOU EVER SUFFERED FROM							a. ANY OTHER CHEST ILLNESSES *If yes, please specify.						
(1) Epilepsy (Or fits, seizures or convulsions)							b. ANY CHEST OPERATIONS *If yes, please specify.						
(2) Rheumatic Fever							c. ANY CHEST INJURIES *If yes, please specify.						
(3) Kidney Disease							27. HEART TROUBLE						
(4) Bladder Disease							a. HAS A DOCTOR EVER TOLD YOU THAT YOU HAD HEART TROUBLE?						
(5) Diabetes							b. IF YES, HAVE YOU EVER HAD TREATMENT FOR HEART TROUBLE IN THE PAST TEN YEARS?						
(6) Jaundice							28. HIGH BLOOD PRESSURE						
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							a. HAS A DOCTOR EVER TOLD YOU THAT YOU HAD HIGH BLOOD PRESSURE (Hypertension)?						
20. CHEST ILLNESSES							b. IF YES, HAVE YOU EVER HAD TREATMENT FOR HIGH BLOOD PRESSURE IN THE PAST TEN YEARS?						
a. DURING THE PAST THREE YEARS, HAVE YOU HAD ANY CHEST ILLNESSES THAT HAVE KEPT YOU OFF WORK, INDOORS AT HOME, OR IN BED?							29. WHEN DID YOU LAST HAVE YOUR CHEST X-RAYED? (Year)						
b. IF YES, DID YOU PRODUCE PHLEGM WITH ANY OF THESE ILLNESSES?							30. CHEST X-RAY						
c. IN THE LAST THREE YEARS, HOW MANY SUCH ILLNESSES WITH INCREASED PHLEGM DID YOU HAVE WHICH LASTED A WEEK OR MORE? (List number)							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			Mother			38. BREATHLESSNESS			Yes	No	N/A
		Yes	No	Don't Know	Yes	No	Don't Know	a. ARE YOU TROUBLED BY SHORTNESS OF BREATH WHEN HURRYING ON THE LEVEL OR WALKING UP A SLIGHT HILL?					
a. CHRONIC BRONCHITIS								b. IF YES, DO YOU HAVE TO WALK SLOWER THAN PEOPLE OF YOUR AGE ON THE LEVEL BECAUSE OF BREATHLESSNESS?					
b. EMPHYSEMA								c. DO YOU EVER HAVE TO STOP FOR BREATH WHEN WALKING AT YOUR OWN PACE ON THE LEVEL?					
c. ASTHMA								d. DO YOU EVER HAVE TO STOP FOR BREATH AFTER WALKING ABOUT 100 YARDS (or after a few minutes) ON THE LEVEL?					
d. LUNG CANCER								e. ARE YOU TOO BREATHLESS TO LEAVE THE HOUSE OR BREATHLESS ON DRESSING OR CLIMBING ONE FLIGHT OF STAIRS?					
e. OTHER CHEST CONDITIONS								39. CIGARETTE SMOKING					
f. IS PARENT CURRENTLY ALIVE?								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.					*
g. Please specify		AGE IF LIVING		AGE AT DEATH				b. IF YES, DO YOU NOW SMOKE CIGARETTES? (As of one month ago)?					
CAUSE OF DEATH		Father: <input type="checkbox"/> N/A		Mother: <input type="checkbox"/> N/A				c. HOW OLD WERE YOU WHEN YOU FIRST STARTED REGULAR CIGARETTE SMOKING? (Number of years)					
32. COUGH								d. IF YOU HAVE STOPPED SMOKING CIGARETTES COMPLETELY, HOW OLD WERE YOU WHEN YOU STOPPED? (List age in (1) or X (2))					
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.						*		(1) Age in years <input type="checkbox"/> (2) Still smoking					
b. DO YOU USUALLY COUGH AS MUCH AS FOUR TO SIX TIMES A DAY FOUR OR MORE DAYS OUT OF THE WEEK?								e. HOW MANY CIGARETTES DO YOU SMOKE PER DAY NOW?					
c. DO YOU USUALLY COUGH AT ALL ON GETTING UP OR FIRST THING IN THE MORNING?								f. ON THE AVERAGE OF THE ENTIRE TIME YOU SMOKED, HOW MANY CIGARETTES DID YOU SMOKE PER DAY?					
d. DO YOU USUALLY COUGH AT ALL DURING THE REST OF THE DAY OR AT NIGHT?								g. DO OR DID YOU INHALE CIGARETTE SMOKE (X one)					
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.								(1) Not at all <input type="checkbox"/> (2) Slightly <input type="checkbox"/> (3) Moderately <input type="checkbox"/> (4) Deeply					
e. DO YOU USUALLY COUGH LIKE THIS ON MOST DAYS FOR THREE CONSECUTIVE MONTHS OR MORE DURING THE YEAR?								40. PIPE SMOKING					
f. FOR HOW MANY YEARS HAVE YOU HAD THE COUGH?								a. HAVE YOU EVER SMOKED A PIPE REGULARLY? *Yes means more than 12 oz. of tobacco in a lifetime.				*	
33. PHLEGM						*		b. HOW OLD WERE YOU WHEN YOU FIRST STARTED PIPE SMOKING? (Number of years)					
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.								c. IF YOU HAVE STOPPED SMOKING A PIPE COMPLETELY, HOW OLD WERE YOU WHEN YOU STOPPED? (List age in (1) or X (2))					
b. DO YOU USUALLY BRING UP PHLEGM LIKE THIS AS MUCH AS TWICE A DAY FOUR OR MORE DAYS OUT OF THE WEEK?								(1) Age in years <input type="checkbox"/> (2) Still smoking					
c. DO YOU USUALLY BRING UP PHLEGM AT ALL ON GETTING UP OR FIRST THING IN THE MORNING?								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.)					
d. DO YOU USUALLY BRING UP PHLEGM AT ALL DURING THE REST OF THE DAY OR AT NIGHT?								e. HOW MUCH PIPE TOBACCO DO YOU SMOKE PER WEEK NOW?					
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.								f. DO OR DID YOU INHALE PIPE SMOKE (X one)					
e. DO YOU USUALLY BRING UP PHLEGM LIKE THIS ON MOST DAYS FOR THREE CONSECUTIVE MONTHS OR MORE DURING THE YEAR?								(1) Not at all <input type="checkbox"/> (2) Slightly <input type="checkbox"/> (3) Moderately <input type="checkbox"/> (4) Deeply					
f. FOR HOW MANY YEARS HAVE YOU HAD TROUBLE WITH PHLEGM?								41. CIGAR SMOKING					
34. EPISODES OF COUGH AND PHLEGM								a. HAVE YOU EVER SMOKED CIGARS REGULARLY? *Yes means more than 1 cigar a week for a year.				*	
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. HOW OLD WERE YOU WHEN YOU FIRST STARTED REGULAR CIGAR SMOKING? (Number of years)					
b. FOR HOW LONG HAVE YOU HAD AT LEAST ONE SUCH EPISODE PER YEAR? (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))					
35. WHEEZING/WHISTLING								(1) Age in years <input type="checkbox"/> (2) Still smoking					
a. DOES YOUR CHEST EVER SOUND WHEEZY OR WHISTLING								d. ON THE AVERAGE OF THE ENTIRE TIME YOU SMOKED, HOW MANY CIGARS DID YOU SMOKE PER WEEK?					
(1) When you have a cold								e. HOW MANY CIGARS DO YOU SMOKE PER WEEK NOW?					
(2) Occasionally apart from colds								f. DO OR DID YOU INHALE CIGAR SMOKE (X one)					
(3) Most days or nights								(1) Not at all <input type="checkbox"/> (2) Slightly <input type="checkbox"/> (3) Moderately <input type="checkbox"/> (4) Deeply					
b. IF YES TO 35.a.(1), (2) or (3), FOR HOW MANY YEARS HAS THIS BEEN PRESENT (Number of years)								43. SIGNATURE			44. DATE SIGNED (YYYYMMDD)		
36. WHEEZING/SHORTNESS OF BREATH								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.					
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?													