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ASBESTOS PROGRAM – PART 2 PERIODIC MEDICAL QUESTIONNAIRE

This mandatory form contains the medical questionnaire that must be administered to all personnel who are exposed to asbestos above the permissible exposure limit, and who will therefore be included in the UW medical surveillance program for asbestos. Part 2 is the abbreviated Periodic Medical Questionnaire, which must be administered to all personnel who are provided periodic medical examinations under the medical surveillance provisions of the asbestos standard (29 CFR 1926.1101).

ASBESTOS EXPOSURE
PART 2 – PERIODIC MEDICAL QUESTIONNAIRE

IDENTIFICATION

1. NAME (Last, First, Middle Initial)**:**	**2. SOCIAL SECURITY NO:**	**3. CLOCK NO:**	**4. PRESENT OCCUPATION:**

5. LOCATION:	**6. STREET ADDRESS:**	**7. CITY, STATE, AND ZIP CODE:**

8. PHONE NO:	**9. INTERVIEWER:**	**10. DATE** (MM/DD/YYYY)**:**	**11. MARITAL STATUS:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced/Separated

12. OCCUPATIONAL HISTORY

		YES	NO	N/A
12A.	In the past year, did you work full-time (30 hour per week or more) for six (6) months or more?	☐	☐	
	If "Yes" to 12A:			
12B.	In the past year, did you work in a dusty job?	☐	☐	☐
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?	☐	☐	
12E.	Was exposure: 1. ☐ Mild 2. ☐ Moderate 3. ☐ Severe			
12F.	In the past year, what was your: 1. Job occupation: _____ 2. Position/Job title: _____			

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13. RECENT MEDICAL HISTORY		YES	NO	N/A
13A.	Do you consider yourself in good health? If "No", state reason: _____	☐	☐	
13B.	In the past year, have you developed: a. Epilepsy (or fits, seizures, convulsions)? b. Rheumatic fever? c. Kidney disease? d. Bladder disease? e. Diabetes? f. Jaundice? g. Cancer?	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	
14. CHEST COLDS AND CHEST ILLNESSES		**Yes**	**No**	**N/A**
14A.	If you get a cold, does it "usually" go to your chest (usually means more than ½ the time)? ☐ 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? If "Yes" to 15A:	☐	☐	
15B.	Did you produce phlegm with any of these chest illnesses?	☐	☐	☐
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			

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16. RESPIRATORY SYSTEM			
In the past year, have you had:			
	Further comment on positive "Yes" answers:		
Asthma?		☐	☐
Bronchitis?		☐	☐
Hay Fever?		☐	☐
Other Allergies?		☐	☐
Pneumonia?		☐	☐
Tuberculosis?		☐	☐
Chest Surgery?		☐	☐
Other Lung Problems?		☐	☐
Heart Disease?		☐	☐
Do you have:			
	Further comment on positive "Yes" answers:		
Frequent colds:		☐	☐
Chronic cough?		☐	☐
Shortness of breath when walking or climbing one flight of stairs?		☐	☐
Do you:			
	Further comment on positive "Yes" answers:		
Wheeze?		☐	☐
Cough up phlegm?		☐	☐
Smoke cigarettes? _____ Packs per day.	How many years? _____	☐	☐

Signature: _____ **Date:** _____

Print Name: _____

Note: This form contains confidential medical information! Submit this completed form to the physician or other licensed health care professional at your scheduled appointment. Do not send this completed form to the UW Safety Office or your Supervisor.

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