Glendale Adventist Medical Center

Adventist Health

Periodical Medical Questionnaire for Exposure to Asbestos Dust and / or Medical Clearance for Respirator Use

Affiliated with Pacific Occupational Medial Associates

Personal Information

Date: _____

Name: _____
Last First Middle

Address: _____
Number / Street Apt / Unit Number

_____
City State Zip Code

Telephone Home: _____ Work: _____

Date of Birth: _____ - _____ - _____ Age: _____
Month Day Year

Employee I.D. # _____ * Sex: (check one) ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

* Ethnic Group (check): (check predominate one if more than one)
☐ American Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic Other _____

**** This information is important in determining predicted values for lung functions tests.***

Employer: _____

Clock or Employee ID Number: _____

1. OCCUPATIONAL HISTORY

IN THE PAST YEAR:

Did your job title / duties change? ☐ Yes ☐ No
If yes, please describe: _____

Did you work 30 hours per week or more, for 6 months or more? ☐ Yes ☐ No

Did you work in a dusty job? ☐ Yes ☐ No
If yes, was exposure: ☐ Mild ☐ Moderate ☐ Severe

Were you exposed to gas or chemical fumes in your work? ☐ Yes ☐ No
If yes, what type? _____
Was exposure ☐ Mild ☐ Moderate ☐ Severe

2. RECENT MEDICAL HISTORY

Do you consider yourself to be in good health?	☐ Yes	☐ No
In the past year or since your last examination, if longer, have you had or developed:		
Epilepsy or seizures	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Kidney or Bladder Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Asthma or Bronchitis	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No
Other allergies (except hay fever)	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Other lung problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chest Surgery	☐ Yes	☐ No
Chest Injuries	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Recurrent or severe chest pains	☐ Yes	☐ No
Fainting / Loss of consciousness	☐ Yes	☐ No
Recurrent dizzy spells	☐ Yes	☐ No
Blood in your stool	☐ Yes	☐ No
Operations or hospitalizations	☐ Yes	☐ No

Comments: Explain "Yes" responses _____

Do you have:

Frequent colds?	☐ Yes	☐ No
Chronic cough?	☐ Yes	☐ No
Shortness of breath when walking of climbing one flight of stairs?	☐ Yes	☐ No

Do you:

Wheeze?	☐ Yes	☐ No
Cough up phlegm?	☐ Yes	☐ No
Smoke Cigarettes?	☐ Yes	☐ No

Packs per day _____ Number of years _____

If you get a cold, does it *usually* got to your chest? (Usually means more than half the time)	☐ Yes	☐ No
During the past year, have you had any chest illnesses that have kept you off work, indoors at home or in bed?	☐ Yes	☐ No
If yes, Did you produce phlegm with any of these chest illnesses?	☐ Yes	☐ No

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

Have you ever had problems with wearing a respirator? ☐ Yes ☐ No

If yes, describe: _____

List the medicines or drugs you take regularly:

Name of Drug	Reason

_____ _____ _____

Your Signature Date Time

FOR PHYSICIAN COMMENTS ONLY:

_____ _____ _____

Physicians Signature Date Time