

Longview Clinic
 3331 Washington Way
 Longview, WA 98632
 360.578.2527 voice
 360.575.1460 fax
 www.hwnw.org



Chehalis Clinic
 1595 N. National Ave #2
 Chehalis, WA 98532
 360.740.0444 voice
 360.740.0704 fax
 www.hwnw.org

BASELINE ASBESTOS QUESTIONNAIRE

Interviewer: _____

Date _____

Patient Information

Last _____ First _____ M.I. _____

Address _____

City _____ State _____ ZIP _____

Birthdate ____/____/____ Social Security Number ____/____/____

Present Occupation _____

SEX Male Female **MARITAL STATUS** Single Married Widowed Separated/Divorced

RACE White Black Asian Hispanic Indian Other

What is the highest grade completed in school? (12 years is completion of high school) _____

	Occupational History	YES	NO	Does Not Apply
1. <i>If yes:</i>	A. Have you ever worked full time (30 hours per week or more for 6 months or more)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Have you ever worked for a year or more in a dusty job? Specify job/industry _____ Total Years Worked _____ Was dust exposure: (circle) Mild Moderate Severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Have you ever been exposed to gas or chemical fumes in your work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	D. What has been your usual occupation or job (the one you have worked at the longest?) Job/occupation: _____ Number of years employed in this occupation? _____ Position/Job title _____ Business, field or industry _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	E. Have you ever worked: (Record on the lines, the years you have worked in any of these industries, for example, 1960-69) In a mine? _____ In a quarry? _____ In a foundry? _____ In a pottery? _____ In a cotton, flax or hemp mill? _____ With asbestos? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.	Medical History	YES	NO	Does Not Apply
	A. Do you consider yourself to be in good health? If NO, please state reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Have you any defect or vision? If YES, please state nature of defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Have you any hearing defect? If YES please state nature of defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	D. Are you suffering from or have you ever suffered from:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES NO Does Not Apply			
	Epilepsy (or fits, seizures, convulsions)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bladder disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Jaundice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chest Colds and Chest Illnesses			
3.	If you get a cold, does it <i>usually</i> go to your chest? (Usually means more than 1/2) the time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Did you have any lung trouble before the age of 16?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES NO Does Not Apply			
	A. Epilepsy (or fits, seizures, convulsions)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Produce any phlegm with these chest illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. How many such illnesses with increased phlegm did you have which lasted a week or more?			
	Have you ever had any of the following:			
6.	Attacks of bronchitis? If YES:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES NO Does Not Apply			
	A. Was it confirmed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. At what age was your first attack? (in years) _____			
7.	Pneumonia (include bronchopneumonia) If YES:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES NO Does Not Apply			
	A. Was it confirmed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Chronic Bronchitis? If YES:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES NO Does Not Apply			
	A. Was it confirmed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Do you still have it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	C. At what age was did it start? (in years) _____																															
9.	Emphysema? If YES: <table border="0"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> <td style="text-align: center;">Does Not Apply</td> </tr> <tr> <td>A. Was it confirmed by a doctor?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>B. Do you still have it?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>C. At what age was did it start? (in years) _____</td> <td></td> <td></td> <td></td> </tr> </table>		YES	NO	Does Not Apply	A. Was it confirmed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B. Do you still have it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C. At what age was did it start? (in years) _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
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10.	Asthma? If YES: <table border="0"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> <td style="text-align: center;">Does Not Apply</td> </tr> <tr> <td>A. Was it confirmed by a doctor?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>B. Do you still have it?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>C. At what age was did it start? (in years) _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>D. If you no longer have it, what age did it stop? _____</td> <td></td> <td></td> <td></td> </tr> </table>		YES	NO	Does Not Apply	A. Was it confirmed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B. Do you still have it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C. At what age was did it start? (in years) _____				D. If you no longer have it, what age did it stop? _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
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11.	Ever have any other chest problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
12.	Ever have any chest operations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
13.	Ever have any chest injuries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
14.	Has a doctor ever told you that you have heart trouble? If YES: <table border="0"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> <td style="text-align: center;">Does Not Apply</td> </tr> <tr> <td>A. have you ever had treatment for heart trouble in the past 10 years?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		YES	NO	Does Not Apply	A. have you ever had treatment for heart trouble in the past 10 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
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15.	Has a doctor ever told you that you had high blood pressure? If YES: <table border="0"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> <td style="text-align: center;">Does Not Apply</td> </tr> <tr> <td>A. Have you had any treatment for high blood pressure (hypertension) in the past 10 years?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		YES	NO	Does Not Apply	A. Have you had any treatment for high blood pressure (hypertension) in the past 10 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
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16.	When did you last have your chest X-rayed (YEAR) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
17.	Where did you last have your chest X-rayed (if known) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
Family History																																
19.	Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
	<table border="1"> <thead> <tr> <th></th> <th colspan="3">Father</th> <th colspan="3">Mother</th> </tr> <tr> <th></th> <th>YES</th> <th>NO</th> <th>D/K</th> <th>YES</th> <th>NO</th> <th>D/K</th> </tr> </thead> <tbody> <tr> <td>A. Chronic bronchitis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>B. Emphysema</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Father			Mother				YES	NO	D/K	YES	NO	D/K	A. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
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	C. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	D. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	E. Other chest conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	F. Is parent currently alive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	G. Please specify Age, if living _____ Age at death _____ Don't Know _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	H. Please specify cause of death _____									
20.	Cough									
			YES	NO	Does Not Apply					
	A. Do you usually cough?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
	B. Do you usually cough as much as 4-6 times a day for more days/week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
	C. Usually cough at all on getting up or first thing in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
	D. Usually cough at all during the rest of the day or at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
	E.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
F.										

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