ALLIANCE HEALTH RESOURCES
Mobile Division, Ltd.

Interviewer _____ Date _____

Initial
Medical History
ASBESTOS

Name _____

Soc. Sec. No. _____ Clock No. _____

Present Occupation _____

Plant Name/Address/Zip Code: _____

_____ Phone _____

SEX: ☐ Male ☐ Female MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Separated/Divorced

DOB: _____ PLACE OF BIRTH: _____

RACE: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Indian ☐ Other _____

What is highest grade completed in school? (12 yrs. is completion of high school) _____

OCCUPATIONAL HISTORY	**YES**	**NO**	**Does Not Apply**
1. A. Have you ever worked full time (30 hours per week or more) for 6 months or more?	☐	☐	☐
If yes:			
B. Have you ever worked for a year or more in any dusty job?	☐	☐	☐
Specify job/industry _____ Total years worked _____			
Was dust exposure: ☐ Mild ☐ Moderate ☐ Severe			
C. Have you ever been exposed to gas or chemical fumes in your work?	☐	☐	☐
Specify job/industry _____ Total years worked _____			
Was exposure: ☐ Mild ☐ Moderate ☐ Severe			
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 _____			
E. Have you ever worked: *(Record on lines the years you have worked in any of these industries (e.g., 1960-69)*			
a. In a mine?	☐	☐	☐
b. In a quarry?	☐	☐	☐
c. In a foundry?	☐	☐	☐
d. In a pottery?	☐	☐	☐
e. In a cotton, flax or hemp mill?	☐	☐	☐
f. With asbestos?	☐	☐	☐

PAST MEDICAL HISTORY	**YES**	**NO**	**Does Not Apply**
2. A. Do you consider yourself to be in good health?	☐	☐	☐
If "NO", state reason _____			
B. Have you any defect of vision?	☐	☐	☐
If "YES" state nature of defect _____			
C. Have you any hearing defect?	☐	☐	☐
If "YES" state nature of defect: _____			
D. Are you suffering from or have you ever suffered from:			
1. Epilepsy (or fits, seizures, convulsions)?	☐	☐	☐
2. Rheumatic fever?	☐	☐	☐
3. Kidney disease?	☐	☐	☐
4. Bladder disease?	☐	☐	☐
5. Diabetes?	☐	☐	☐
6. Jaundice?	☐	☐	☐

CHEST COLDS AND CHEST ILLNESSES	**YES**	**NO**	**Does Not Apply**
3. If you get a cold, does it *usually* go to your chest? (Usually means more than half the time.)	☐	☐	☐

	Yes	No	Does Not Apply
4. Did you have any lung trouble before the age of 16?	☐	☐	☐
5. a. During the past 3 years, had any chest illnesses that kept you off work, indoors, or in bed?	☐	☐	☐
b. Produce any phlegm with these chest illnesses?	☐	☐	☐
c. How many such illnesses with (increased) phlegm did you have which lasted a week or more?	☐	☐	☐
6. Have you ever had any of the following:			
A. Attacks of bronchitis?	☐	☐	☐
If "YES":			
1. Was it confirmed by a doctor?	☐	☐	☐
2. At what age was your first attack? Age in years _____			
B. Pneumonia (include bronchopneumonia)?	☐	☐	☐
If "YES":			
1. Was it confirmed by a doctor?	☐	☐	☐
2. At what age did you first have it? Age in years _____			
C. Hay Fever?	☐	☐	☐
If "YES":			
1. Was it confirmed by a doctor?	☐	☐	☐
2. At what age did it start? Age in years _____			
D. Chronic bronchitis?	☐	☐	☐
If "YES":			
1. Do you still have it?	☐	☐	☐
2. Was it confirmed by a doctor?	☐	☐	☐
3. At what age did it start? Age in years _____			
E. Emphysema?	☐	☐	☐
If "YES":			
1. Do you still have it?	☐	☐	☐
2. Was it confirmed by a doctor?	☐	☐	☐
3. At what age did it start? Age in years _____			
F. Asthma?	☐	☐	☐
If "YES":			
1. Do you still have it?	☐	☐	☐
2. Was it confirmed by a doctor?	☐	☐	☐
3. At what age did it start? Age in years _____			
4. If you no longer have it, what age did it stop? _____			
7. a. Ever had any other chest illnesses? _____	☐	☐	☐
b. Any chest operations? _____	☐	☐	☐
c. Any chest injuries? _____	☐	☐	☐
8. Has a doctor ever told you that you had heart trouble?	☐	☐	☐
If "YES":			
A. Have you ever had treatment for heart trouble in the past 10 years?	☐	☐	☐
9. Has a doctor ever told you that you had high blood pressure?	☐	☐	☐
If "YES":			
A. Have you had any treatment for high blood pressure (hypertension) in the past 10 years?	☐	☐	☐
10. When did you last have your chest X-rayed? Year _____			☐
11. Where did you last have your chest X-rayed (if known)? _____			☐
What was outcome?			

FAMILY HISTORY

12. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as	FATHER YES	FATHER NO	FATHER Don't Know	MOTHER YES	MOTHER NO	MOTHER Don't Know
A. Chronic Bronchitis	☐	☐	☐	☐	☐	☐
B. Emphysema	☐	☐	☐	☐	☐	☐
C. Asthma	☐	☐	☐	☐	☐	☐
D. Lung Cancer	☐	☐	☐	☐	☐	☐
E. Other chest conditions	☐	☐	☐	☐	☐	☐
F. Is parent currently alive?	☐	☐	☐	☐	☐	☐
G. Please specify ..... Age if living:						
Age at death:						
Don't Know:						
H. Please specify cause of death.						

Cough

13. a. Do you usually cough? ☐ Yes ☐ No
    b. Do you usually cough as much as 4-6 times a day for more days/week? ☐ Yes ☐ No
    c. Usually cough at all on getting up or first thing in morning? ☐ Yes ☐ No
    d. Usually cough at all during the rest of the day or at night? ☐ Yes ☐ No

    If yes to any of the above, answer the following. Otherwise skip to 14a.

    e. Usually cough like this on most days for 3 consecutive months during the year? ☐ Yes ☐ No
    f. How many years have you had this cough? _____

14. a. Do you usually bring up phlegm from your chest? ☐ Yes ☐ No
    b. Usually bring up phlegm as much as 2 times/day for 4 or more days out the week? ☐ Yes ☐ No
    c. Usually bring up phlegm on getting up or first thing in the morning? ☐ Yes ☐ No
    d. Usually bring up phlegm at all during the rest of the day or at night? ☐ Yes ☐ No

    If yes, to any of the above, answer the following, otherwise skip to 15a.

    e. Bring up phlegm like this on most days for 3 consecutive months during the year? ☐ Yes ☐ No
    f. How many years have you had trouble with phlegm?

15. a. Periods of Episodes of (increased*) cough and phlegm 3 weeks or more each year? ☐ Yes ☐ No
    b. If yes: How many years with at least one episode per year? _____ ☐ Does not apply

Wheezing

16. a. Chest ever sound wheezy or whistling?
        1. When you have a cold? ☐ Yes ☐ No
        2. Occasionally apart from colds? ☐ Yes ☐ No
        3. Most days or nights? ☐ Yes ☐ No
    b. If yes 1, 2, or 3: For how many years?

17. a. Any attack of wheezing causing shortness of breath? ☐ Yes ☐ No

    If yes: a. How old were you when you had your first attack?
    b. Have you had 2 or more episodes? ☐ Yes ☐ No
    c. Required medicine or treatment for attacks? ☐ Yes ☐ No

Breathlessness

18. Disabled from walking by any condition other than hear or lung disease. Condition: _____

    a. Troubled by shortness of breath when hurrying level or on a slight hill? ☐ Yes ☐ No

    If yes: a. Walk slower than people your age on the level due to breathlessness? ☐ Yes ☐ No ☐ N/A
    b. Have to stop for breath when walking at your own pace on level? ☐ Yes ☐ No ☐ N/A
    c. Have to stop for breath after walking aabout 100 yards on the level? ☐ Yes ☐ No ☐ N/A
    d. Too breathless to leave the house or on dressing or climbing one flight of stairs? ☐ Yes ☐ No ☐ N/A

Tobacco Smoking

19. Have you ever smoked cigarettes? ☐ Yes ☐ No

    If yes: b. Do you now smoke cigarettes? (As of 1 month ago) ☐ Yes ☐ No ☐ N/A
    c. How old were you when started regular cigarette smoking?
    d. Ever stopped smoking completely and age? _____ ☐ Still Smoking
    e. Cigarettes smoked per day now? _____
    f. On average of entire time smoking, how many cigarettes per day? _____
    g. Do or did you inhale cigarette smoke? ☐ Does not apply ☐ Not at all ☐ Slightly ☐ Moderately ☐ Deeply

20. a. Have you ever smoked a pipe regularly? ☐ Yes ☐ No

For Persons Who Have Ever Smoked a Pipe

    If yes: How old were you when started regular pipe smoking?
    b. Ever stopped smoking completely and age? _____ ☐ Still Smoking ☐ N/A
    c. On average of entire time smoking pipe tobacco, how much per week? _____ oz.
    d. Pipe tobacco per week smoking now? _____ oz.
    e. Do or did you inhale pipe smoke? ☐ Does not apply ☐ Not at all ☐ Slightly ☐ Moderately ☐ Deeply

21. a. Have you ever smoked cigars regularly? ☐ Yes ☐ No

For Persons Who Have Ever Smoked Cigars

    If yes: b. 1. How old were you when started regular cigar smoking?
    2. Ever stopped smoking completely and age? _____ ☐ Still Smoking
    c. On average of entire time smoking cigars, how much per week? _____
    d. Cigars per week smoking now? _____
    e. Do or did you inhale pipe smoke? ☐ Does not apply ☐ Not at all ☐ Slightly ☐ Moderately ☐ Deeply