

Questions to be Included in Initial Medical Exam for Workers Exposed to Occupational Allergens

1. Have you ever seen a doctor regarding:

1a) shortness of breath?

1a) No 1 Yes 2 Unknown 3

If YES,

1b) what year?

1b) _____ year

1c) sinus problems?

1c) No 1 Yes 2 Unknown 3

If YES,

1d) what year?

1d) _____ year

1e) skin rash?

1e) No 1 Yes 2 Unknown 3

If YES,

1f) what year?

1f) _____ year

2. Have you ever had asthma?

2) No 1 Yes 2 Unknown 3

If YES,

2a) what year?

2a) _____ year

2b) Was your asthma confirmed by a doctor?

2b) No 1 Yes 2 Unknown 3

2c) At what age did your asthma start?

2c) ____ age started

2d) If you no longer have asthma, at what age did it stop?

2d) ____ age stopped

3. Do you currently require medicine or treatment for asthma?

3) No 1 Yes 2 Unknown 3

If YES,

3a) What type of medicine? _____

4. Have you ever had

4a) Allergies?

4a) No 1 Yes 2 Unknown 3

If YES,

4b) what year?

4b) ___ ___ ___ year

4c) Hayfever?

4c) No 1 Yes 2 Unknown 3

If YES,

4d) what year?

4d) ___ ___ ___ year

4e) Eczema (skin rash)?

4e) No 1 Yes 2 Unknown 3

If YES,

4f) what year?

4f) ___ ___ ___ year

5. Do your blood relatives; father, mother, brother(s) or sister(s) have allergies, hay fever, asthma or eczema (skin rash)?

5) No 1 Yes 2 Unknown 3

	Father	Mother	Brother(s)	Sister(s)
Allergies	Yes	Yes	Yes	Yes
Hayfever	Yes	Yes	Yes	Yes
Asthma	Yes	Yes	Yes	Yes
Eczema (skin rash)	Yes	Yes	Yes	Yes

6. Do or did you ever smoke cigarettes?

6) No 1 Yes 2 Unknown 3

If YES,

6a) How many packs per day?

6a) ___ packs/day

6b) If you quit smoking, how old were you?

6b) ___ age quit smoking

6c) Do you carry cigarettes into the work place?

6c) No 1 Yes 2 Unknown 3

7. Circle how often any of the following symptoms bother you.

	Never	Seldom	Monthly	Weekly	Daily	Month/Year Symptom Started
Nasal stuffiness	1	2	3	4	5	___/___
Runny nose	1	2	3	4	5	___/___
Tearing, burning of eyes	1	2	3	4	5	___/___
Redness of eyes	1	2	3	4	5	___/___
Swelling of face	1	2	3	4	5	___/___
Hives	1	2	3	4	5	___/___
Sore throat	1	2	3	4	5	___/___
Cough	1	2	3	4	5	___/___
Wheezing	1	2	3	4	5	___/___
Chest tightness	1	2	3	4	5	___/___
Shortness of breath	1	2	3	4	5	___/___
Fever or sweats	1	2	3	4	5	___/___
Chills or shivering	1	2	3	4	5	___/___
Ache all over	1	2	3	4	5	___/___
Unusual tiredness	1	2	3	4	5	___/___

8. Have you ever had emphysema/COPD?

8) No 1 Yes 2 Unknown 3

If YES,

8a) Was your emphysema/COPD confirmed by a breathing test that your doctor gave you?

8a) No 1 Yes 2 Unknown 3

8b) At what age did your emphysema/COPD start?

8b) ___ age started

9. Does your chest ever sound wheezy or whistling:

9a) when you have a cold?

9a) No 1 Yes 2 Unknown 3

9b) occasionally apart from colds?

9b) No 1 Yes 2 Unknown 3

9c) most days or nights?

9c) No 1 Yes 2 Unknown 3

If YES to 9a,9b or 9c:

9d) For how many years has this been present?

9d) ___ # of years

10. Have you ever had an attack of wheezing that has made you feel short of breath?

10) No 1 Yes 2 Unknown 3

If YES to 10:

10a) How old were you when you had your first such attack?

10a) ___ age

10b) Have you had 2 or more such episodes?

10b) No 1 Yes 2 Unknown 3

10c) Have you required medicine or treatment for these attacks?

10c) No 1 Yes 2 Unknown 3

10d) Is there a chemical substance or job at work which you think causes these attacks?

10d) No 1 Yes 2 Unknown 3

If YES, please describe: _____

11. Do you bring up phlegm or mucus most days of the week (4 out of 7 days) for a period of 3 months straight (count phlegm or mucus with first smoke or on first going out-of-doors, don't count phlegm or mucus from your nose).

11) No 1 Yes 2 Unknown 3

If YES to 11:

11a) How many years have you brought up phlegm or mucus?

11a) ___ # of years