

DELAWARE STATE POLICE  
OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE  
Non-specialized Unit

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require medical examination.

To the employee:

Can you read (circle one)? Yes/No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator. (please print)

1. Today's date: \_\_\_\_\_
2. Your name: \_\_\_\_\_
3. Your age (to nearest year): \_\_\_\_\_
4. Sex (circle one): Male/Female
5. Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in.
6. Your weight: \_\_\_\_\_ lbs.
7. Your job title: \_\_\_\_\_
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): \_\_\_\_\_
9. The best time to phone you at this number: \_\_\_\_\_
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one)? Yes/No

The questionnaire reviewer is our contracted medical service provider. Human Resources will forward all documents to their staff for review. Specific contacts within the provider network may be obtained from DSP Human Resources.

11. Check the type of respirator you will use (you can check more than one category):
- N, R, or P disposable respirator (filter-mask, non-cartridge type only).
  - Other type (for example, half or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one)? Yes/No

If "yes" what type(s)? Full-face air purifying respirator

Part A. Section 2 (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?  
Yes/No
2. Have you ever had any of the following conditions?
  - a. Seizures (fits): Yes/No
  - b. Diabetes (sugar disease): Yes/No
  - c. Allergic reactions that interfere with your breathing: Yes/No
  - d. Claustrophobia (fear of closed-in places): Yes/No
  - e. Trouble smelling odors: Yes/No
3. Have you ever had any of the following pulmonary or lung problems?
  - a. Asbestosis: Yes/No
  - b. Asthma: Yes/No
  - c. Chronic bronchitis: Yes/No
  - d. Emphysema: Yes/No
  - e. Pneumonia: Yes/No
  - f. Tuberculosis: Yes/No
  - g. Silicosis: Yes/No
  - h. Pneumothorax (collapsed lung): Yes/No
  - i. Lung Cancer: Yes/No
  - j. Broken ribs: Yes/No
  - k. Any chest injuries or surgeries: Yes/No
  - l. Any other lung problem that you've been told about: Yes/No
4. Do you currently have any of the following symptoms of pulmonary or lung illness?
  - a. Shortness of breath: Yes/No
  - b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No

- c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
  - d. Have to stop for a breath when walking at your own pace on level ground: Yes/No
  - e. Shortness of breath when washing or dressing yourself: Yes/No
  - f. Shortness of breath that interferes with your job: Yes/No
  - g. Coughing that produces phlegm (thick sputum): Yes/No
  - h. Coughing that wakes you up early in the morning: Yes/No
  - i. Coughing that occurs mostly when you are lying down: Yes/No
  - j. Coughing up blood in the last month: Yes/No
  - k. Wheezing: Yes/No
  - l. Wheezing that interferes with your job: Yes/No
  - m. Chest pain when you breathe deeply: Yes/No
  - n. Any other symptoms that you think may be related to lung problems: Yes/No
5. Have you ever had any of the following cardiovascular or heart problems?
- a. Heart attack: Yes/No
  - b. Stroke: Yes/No
  - c. Angina: Yes/No
  - d. Heart failure: Yes/No
  - e. Swelling in your legs or feet (not caused by walking): Yes/No
  - f. Heart arrhythmia (heart beating irregularly): Yes/No
  - g. High blood pressure: Yes/No
  - h. Any other heart problem that you've been told about: Yes/No
6. Have you ever had any of the following cardiovascular or heart symptoms?
- a. Frequent pain or tightness in your chest: Yes/No
  - b. Pain or tightness in your chest during physical activity: Yes/No
  - c. Pain or tightness in your chest that interferes with your job: Yes/No
  - d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
  - e. Heartburn or indigestion that is not related to eating: Yes/No
  - f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No
7. Do you currently take medication for any of the following problems?
- a. Breathing or lung problems: Yes/No
  - b. Heart trouble: Yes/No
  - c. Blood pressure: Yes/No
  - d. Seizures (fits): Yes/No
8. If you've used a respirator, have you ever had any of the following problems? (if you've never used a respirator, check the following space and go to question 9):\_\_

- a. Eye irritation: Yes/No
  - b. Skin allergies or rashes: Yes/No
  - c. Anxiety: Yes/No
  - d. General weakness or fatigue: Yes/No
  - e. Any other problem that interferes with your use of a respirator: Yes/No
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary. **(Must answer as we utilize full-face respirators)**

10. Have you ever lost vision in either eye (temporarily or permanently)? Yes/No
11. Do you currently have any of the following vision problems?
- a. Wear contact lenses: Yes/No
  - b. Wear glasses: Yes/No
  - c. Color blind: Yes/No
  - d. Any other eye or vision problem: Yes/No
12. Have you ever had an injury to your ears, including a broken ear drum? Yes/No
13. Do you currently have any of the following hearing problems?
- a. Difficulty hearing: Yes/No
  - b. Wear a hearing aid: Yes/No
  - c. Any other hearing or ear problem: Yes/No
14. Have you ever had a back injury? Yes/No
15. Do you currently have any of the following musculoskeletal problems?
- a. Weakness in any of your arms, hands, legs, or feet: Yes/No
  - b. Back pain: Yes/No
  - c. Difficulty fully moving your arms and legs: Yes/No
  - d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
  - e. Difficulty fully moving your head up or down: Yes/No
  - f. Difficulty fully moving your head side to side: Yes/No
  - g. Difficulty bending at your knees: Yes/No
  - h. Difficulty squatting to the ground: Yes/No
  - i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No

- j. Any other muscle or skeletal problem that interferes with using a respirator:  
Yes/No

Part B. Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

- 1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? Yes/**No**

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions? Yes/No

- 2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g. gases, fumes, or dust), or have you come into skin contact with hazardous chemicals? Yes/No

If "yes," name the chemicals if you know them: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 3. Have you ever worked with any of the materials, or under any of the conditions, listed below?

- a. Asbestos: Yes/No
- b. Silica (e.g., in sandblasting): Yes/No
- c. Tungsten/cobalt (e.g., grinding or welding this material) Yes/No
- d. Beryllium: Yes/No
- e. Aluminum: Yes/No
- f. Coal (for example, mining): Yes/No
- g. Iron: Yes/No
- h. Tin: Yes/No
- i. Dusty environments: Yes/No
- j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 4. List any second jobs or side businesses you have: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 5. List your previous occupations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. List you current and previous hobbies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason? (including over-the-counter medications) Yes/No

If "yes," name the medications if you know them: \_\_\_\_\_  
\_\_\_\_\_

10. Will you be using any of the following items with your respirator(s)?

- a. HEPA Filters: Yes/No
- b. Canisters (for example, gas mask) Yes/No
- c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?

- a. Escape only (no rescue): Yes/No
- b. Emergency rescue only: Yes/No
- c. Less than 5 hours per week: Yes/No
- d. Less than 2 hours per week: Yes/No
- e. 2 to 4 hours per day: Yes/No
- f. Over 4 hours per day: Yes/No

12. During the period you are using the respirator(s), is your work effort?

- a. Light (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:  
12 hrs. 0 mins.

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

b. Moderate (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:

12 hrs. 0 mins.

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. Heavy (above 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:

12 hrs. 0 mins.

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? Yes/No

If "yes," describe this protective clothing and/or equipment:

**Chemical protective suit and law enforcement gear belt, rain gear**

14. Will you be working under hot conditions (temperature exceeding 77 deg. F)? Yes/No

15. Will you be working under humid conditions? Yes/No

16. Describe the work you'll be doing while you're using your respirator(s)?

**Victim rescue, site security and patrol operations**

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases)?

**WMD agents, bodily fluids, crowd control and riot control agents**

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s)? Unknown

Name of the first toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of second toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of third toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

The name of any other toxic substance that you'll be exposed to while using your respirator: \_\_\_\_\_

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security)?

**Rescue and security, crowd and traffic control**

\_\_\_\_\_  
Officer's Signature

\_\_\_\_\_  
Date

# DELAWARE STATE POLICE - MEDICAL HISTORY FORM

NAME	DATE	
WORK LOCATION/ASSIGNMENT	DATE OF BIRTH	AGE

### HOSPITAL ADMISSIONS

YEAR	ILLNESS/OPERATION

### IMMUNIZATIONS

Approximate date of last injection	<input type="checkbox"/> SMALL POX	<input type="checkbox"/> DIPHTHERIA
	<input type="checkbox"/> TYPHOID	<input type="checkbox"/> PERTUSSIS
	<input type="checkbox"/> MEASLES	<input type="checkbox"/> POLIO
	<input type="checkbox"/> MUMPS	<input type="checkbox"/> TETANUS
	<input type="checkbox"/> RUBELLA	<input type="checkbox"/> FLU

### MEDICATIONS

List medications you are now taking	

### DRUG ALLERGIES

List known drug allergies	

### CHECK ALL APPLICABLE BOXES

#### CHILDHOOD DISEASES

- MEASLES
- MUMPS
- GERMAN MEASLES
- CHICKEN POX
- POLIO
- SCARLET FEVER
- RHEUMATIC FEVER

#### GI

- FREQUENT INDIGESTION
- STOMACH OR DUODENAL ULCER
- JAUNDICE/HEPATITIS
- CHRONIC ABDOMINAL PAIN
- BLOOD IN STOOL
- LIVER DISEASE
- VOMIT BLOOD
- RECENT CHANGE IN BOWEL HABITS
- HERNIAS
- RECENT WEIGHT LOSS

#### GU

- KIDNEY DISEASE
- FREQUENT URINATION
- GREATER THAN 2 NIGHTTIME URINATIONS
- BLOOD IN URINE
- FREQUENT URINARY TRACT INFECTION
- DIFFICULTY URINATING
- LOSS OF BLADDER CONTROL
- VENEREAL DISEASE

#### MUSCULOSKELETAL

- RECURRENT BACK/NECK PAIN
- PINCHED NERVE
- NUMBNESS OR TINGLING
- MUSCLE WEAKNESS
- GOUT
- JOINT INJURY
- CHRONIC JOINT PAIN
- ARTHRITIS
- BROKEN BONES
- LEG PAIN W/WALKING
- FOOT OR LEG SWELLING
- VARICOSE VEINS

#### CV

- CHEST PAIN
- ANGINA
- PALPITATIONS
- SHORT OF BREATH
- IRREGULAR PULSE
- HEART MURMUR
- HEART ATTACK
- HIGH BLOOD PRESSURE
- HIGH TRIGLYCERIDES
- HIGH CHOLESTEROL
- EMPHYSEMA
- ASTHMA/WHEEZING
- TUBERCULOSIS
- FAINTING SPELLS
- COLLAPSED LUNG

#### HEENT

- HEAD INJURY
- SINUS PROBLEMS
- POOR OR BLURRED VISION
- LOSS OF VISION
- CORRECTIVE LENSES
- EYE PAIN
- DOUBLE VISION
- EAR PAIN
- LOSS/DECREASE IN HEARING
- VERTIGO/DIZZINESS
- FREQUENT NOSEBLEEDS
- PROLONGED HOARSENESS
- DIFFICULTY SWALLOWING
- FREQUENT SORE THROAT

#### NEURO

- DIFFICULTY SLEEPING/SNORING
- DAYTIME DROWSINESS
- PHOBIAS
- DEPRESSION
- MEMORY LOSS
- MIGRAINE/CHRONIC HEADACHES
- SEIZURES/CONVULSIONS
- PSYCHIATRIC HOSPITALIZATION

#### GENERAL

- CANCER
- ANEMIA
- THYROID DISEASE
- OTHER

HAVE YOU BEEN REFUSED EMPLOYMENT BECAUSE OF HEALTH?  NO  YES WHY \_\_\_\_\_

HAVE YOU BEEN UNABLE TO KEEP A JOB FOR ANY OF THESE REASONS?

- SENSITIVITY TO DUST OR CHEMICAL?  NO  YES EXPLAIN \_\_\_\_\_
- MEDICAL OR HEALTH REASON?  NO  YES EXPLAIN \_\_\_\_\_
- LIMITED OR PAINFUL MOTION?  NO  YES EXPLAIN \_\_\_\_\_
- ALCOHOL OR DRUG USE?  NO  YES EXPLAIN \_\_\_\_\_

HAVE YOU EVER CLAIMED OR RECEIVED WORKERS' COMPENSATION FOR A WORK RELATED INJURY/ILLNESS?

NO  YES EXPLAIN \_\_\_\_\_

HAVE YOU HAD AN INJURY/ILLNESS IN THE PAST 5 YEARS WHICH CAUSED MORE THAN 5 DAYS ABSENCE FROM WORK?

NO  YES EXPLAIN \_\_\_\_\_

**I HEREBY CERTIFY THAT I HAVE ANSWERED THE ABOVE QUESTIONS TRUTHFULLY AND TO THE BEST OF MY ABILITY.**

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

# DELAWARE STATE POLICE - MEDICAL HISTORY FORM

## PHYSICAL EXAM

VITAL SIGNS HT \_\_\_\_\_ WT \_\_\_\_\_ TEMP \_\_\_\_\_ RR \_\_\_\_\_ PULSE \_\_\_\_\_ BPRA \_\_\_\_\_ / \_\_\_\_\_ LA \_\_\_\_\_ / \_\_\_\_\_

GENERAL APPEARANCE \_\_\_\_\_

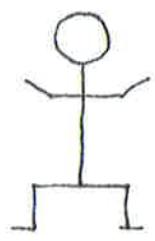
**AUDIOMETRIC SCREEN - COPY OF CHARTED READINGS REQUIRED**

NORMAL     ABNORMAL

COMMENTS

	NORMAL	ABNORMAL	
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
NECK	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART	<input type="checkbox"/>	<input type="checkbox"/>	_____
LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	_____
CHEST	<input type="checkbox"/>	<input type="checkbox"/>	_____
ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	_____
SPINE	<input type="checkbox"/>	<input type="checkbox"/>	_____
SKIN	<input type="checkbox"/>	<input type="checkbox"/>	_____
EXTREMITIES			
UPPER	<input type="checkbox"/>	<input type="checkbox"/>	_____
LOWER	<input type="checkbox"/>	<input type="checkbox"/>	_____
NEURO	<input type="checkbox"/>	<input type="checkbox"/>	_____
TO BE DONE AT THE OPTION OF THE EMPLOYEE			
RECTAL	<input type="checkbox"/>	<input type="checkbox"/>	_____
PELVIC	<input type="checkbox"/>	<input type="checkbox"/>	_____
BREAST	<input type="checkbox"/>	<input type="checkbox"/>	_____
GENITALIA	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER TEST REQUESTED BY PHYSICIAN			_____

REFLEXES



**SYNOPSIS** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DRS. SIGNATURE \_\_\_\_\_

DATE OF EXAM \_\_\_\_\_

- |  |                              |                                     |                                     |
|--|------------------------------|-------------------------------------|-------------------------------------|
| Medically qualified for job            | <input type="checkbox"/> YES | <input type="checkbox"/> Wilmington | <input type="checkbox"/> Georgetown |
| Patient advised of positive findings   | <input type="checkbox"/> YES | <input type="checkbox"/> Newark     | <input type="checkbox"/> Seaford    |
| Patient referred to personal physician | <input type="checkbox"/> YES | <input type="checkbox"/> Dover      |                                     |

**WorkPRO Locations**

PLACE U/A STRIP HERE

# DELAWARE STATE POLICE



## PERSONAL HEALTH HISTORY

This Medical Information Examination is totally confidential; access to this information will be strictly limited to authorized personnel only.

Name \_\_\_\_\_

DIRECTIONS: Read each question carefully, if your answer is YES, circle YES. Any question with an X following the number that has been answered YES is to be explained on a separate sheet. If your answer is NO, make no mark and move to the next question.

**I. FAMILY HISTORY**

**Do any of your blood relatives (mother, father, brothers, sisters, aunts or uncles) have any of the following?**

- |                                      |     |
|--------------------------------------|-----|
| 1. Diabetes (sugar in the blood)     | YES |
| 2. Tuberculosis (T.B.)               | YES |
| 3. Lung Cancer                       | YES |
| 4. Cancer                            | YES |
| 5. Heart Disease                     | YES |
| 6. Coronary Artery Disease           | YES |
| 7. High Blood Pressure               | YES |
| 8. Stroke                            | YES |
| 9. Asthma                            | YES |
| 10. Hay Fever                        | YES |
| 11. Mental or Nervous Disease        | YES |
| 12. Depression                       | YES |
| 13. Bleeding Tendency (Free Bleeder) | YES |
| 14. Stomach or Peptic Ulcer          | YES |
| 15. Arthritis                        | YES |
| 16. Alcoholism                       | YES |
| 17. Kidney Disease                   | YES |
| 18. Cataracts                        | YES |
| 19. Glaucoma                         | YES |
| 20. Cirrhosis of Liver               | YES |
| 21. Gout                             | YES |

**Did any of your blood relatives (mother, father, brothers, sisters, aunts, or uncles) die from any of the following?**

- |                                      |     |
|--------------------------------------|-----|
| 22. Diabetes                         | YES |
| 23. Tuberculosis                     | YES |
| 24. Lung Disease                     | YES |
| 25. Cancer                           | YES |
| 26. Heart Disease                    | YES |
| 27. Coronary Artery Disease          | YES |
| 28. High Blood Pressure              | YES |
| 29. Stroke                           | YES |
| 30. Asthma                           | YES |
| 31. Bleeding Tendency (Free Bleeder) | YES |
| 32. Stomach or Peptic Ulcer          | YES |
| 33. Alcoholism                       | YES |
| 34. Kidney Disease                   | YES |
| 35. Cirrhosis of Liver               | YES |

**II. PAST HISTORY**

**Has the doctor ever told you that you have or had any of the following illness or disease?**

- |   |       |
|---|-------|
| 36. Glaucoma (high pressure in the eye) | YES X |
| 37. Cataracts                           | YES X |

38. Blindness (either eye)	YES X
39. Hay Fever	YES X
40. Pneumonia	YES X
41. Bronchitis	YES X
42. Pleurisy	YES X
43. Asthma	YES X
44. Emphysema	YES X
45. Tuberculosis	YES X
46. Heart Disease	YES X
47. Rheumatic Fever	YES X
48. High Blood Pressure	YES X
49. Angina Pectoris	YES X
50. Enlarged Heart	YES X
51. Phlebitis (inflammation of veins in arms or legs)	YES X
52. Varicose Veins	YES X
53. Malaria	YES X
54. Duodenal Ulcer	YES X
55. Stomach Ulcer	YES X
56. Gastritis (inflammation of stomach)	YES X
57. Nervous stomach	YES X
58. Hepatitis	YES X
59. Hernia or Rupture	YES X
60. Cirrhosis (a liver disease)	YES X
61. Jaundice (yellow skin or eyes)	YES X
62. Gallstones	YES X
63. Mononucleosis (Glandular Fever, Kissing Disease)	YES X
64. Colitis	YES X
65. Cancer	YES X
66. Syphilis (lues of bad blood)	YES X
67. Gonorrhea (Clap)	YES X
68. Nephritis (Bright's Disease)	YES X
69. Kidney Stones (Gravel)	YES X
70. Bladder or Kidney infection	YES X
71. Polio	YES X
72. Epilepsy or frequent convulsions	YES X
73. Stroke or Brain Hemorrhage	YES X
74. Paralysis	YES X
75. Nervous Tension	YES X
76. Gout	YES X
77. Arthritis or Rheumatism	YES X
78. Psoriasis	YES X
79. Anemia (Low Blood)	YES X
80. Diabetes (Sugar in the blood)	YES X
81. Goiter (Enlarged thyroid)	YES X
83. Hypo (underactive thyroid)	YES X
84. Scarlet Fever	YES X
85. Mumps	YES
86. Measles	YES
87. Chicken Pox	YES
88. German Measles	YES
89. Have you ever had some other serious illness which is not listed above?	YES X

**Have you ever had an operation on any of the following parts of your body?**

- |  |       |
|--|-------|
| 90. Tonsils  | YES X |
| 91. Lung   | YES X |
| 92. Heart  | YES X |
| 93. An artery or arteries  | YES X |
| 94. A vein or veins  | YES X |
| 95. Stomach  | YES X |
| 96. Gallbladder  | YES X |
| 97. Appendix   | YES X |
| 98. Pancreas   | YES X |
| 99. Bowel or Intestine   | YES X |
| 100. Rectum  | YES X |
| 101. Anus or Hemorrhoids (Piles)   | YES X |
| 102. Kidney  | YES X |
| 103. Bladder   | YES X |
| 104. Hernia (or rupture)   | YES X |
| 105. Bones (or fractures)  | YES X |
| 106. Joints  | YES X |
| 107. Back or Spine   | YES X |
| 108. Thyroid Gland   | YES X |
| 109. Operation on male or female parts   | YES X |
| 110. Operation on some other parts of your body not listed above?  | YES X |
| 111. Have you ever had a back injury?  | YES X |
| 112. Have you ever worked where you were exposed to chemicals, dirt particles, gasses, fumes, loud noises, x rays, poisons, sprays, lasers, or other surroundings which might have affected your health? | YES   |
| 113. Do you have any type of chronic illness?  | YES X |
| 114. During the past year, have you taken aspirin, empirin, anacin or bufferin almost every day?   | YES   |
| 115. During the past year, have you taken a sleeping pill almost every night?  | YES X |

**Have you taken the following medicines in the last month?**

- |   |       |
|---|-------|
| 116. Tranquilizers, sedatives or nerve pills? | YES X |
| 117. Nitroglycerine                           | YES X |
| 118. Digitalis or other heart pills           | YES X |
| 119. Diuretics or water pills                 | YES X |
| 120. Antibiotics                              | YES   |
| 121. Pills to lower blood pressure            | YES X |
| 122. Cortisone or other steroids              | YES X |
| 123. Thyroid medication                       | YES X |
| 124. Birth Control Pills                      | YES   |
| 125. Pep pills or Mood Elevators              | YES X |
| 126. Blood thinners (anti-coagulants)         | YES X |
| 127. Pain Killers                             | YES   |
| 128. Weight reducing pills                    | YES X |
| 129. Vitamins                                 | YES   |
| 130. Laxatives                                | YES   |
| 131. Iron Pills                               | YES   |

**Have you had any of the following examinations in the last two years?**

- |  |       |
|--|-------|
| 132. A complete physical exam  | YES   |
| 133. Blood pressure check  | YES   |
| 134. Chest X-ray   | YES   |
| 135. Blood test for anemia or low hemoglobin   | YES   |
| 136. Urine test  | YES   |
| 137. Barium enema  | YES   |
| 138. Proctoscopy (rectal examination involving insertion of a metal tube)                      | YES   |
| 139. Electrocardiogram (EKG)   | YES   |
| 140. Eye examination   | YES   |
| 141. Blood test for diabetes   | YES   |
| 142. Blood test for cholesterol  | YES   |
| 143. Vaccination for smallpox  | YES   |
| 144. Do you often have disturbing numbness in your hands or feet that comes on during the day? | YES X |
| 145. Have you had any Vitamin B-12 injections during the past two years?                       | YES   |

**III. PRESENT CONDITION**

- |   |     |
|---|-----|
| 146. During the past year, have you noticed that heat or hot weather bothers you more than in past years? | YES |
| 147. During the past six months, have you been drinking more water and other liquids than you used to?    | YES |
| 148. Have you started using more salt on your food during the past year or so?                            | YES |
| 149. Does your hair fall out easily?  | YES |
| 150. Has your hair changed in amount or texture within the last year?                                     | YES |
| 151. Have you had any infections or diseases of the skin?   | YES |
| 152. Are you bothered by severe itching?  | YES |
| 153. Do you perspire excessively?   | YES |
| 154. Do you have any skin rashes in the past year which are still present?                                | YES |
| 155. During the past year, have you noticed any new growths on your skin?                                 | YES |
| 156. Sore that do not heal?   | YES |
| 157. Enlarged moles?  | YES |
| 158. Hives or welts?  | YES |
| 159. Do you often get skin or nail infections?  | YES |

160. Have you noticed any recent change in the color of your skin?	YES
161. Darker (other than suntan)	YES
162. Yellow	YES
163. Some other color changes	YES
164. Do you have a medical or personal complaint you would like to discuss with your doctor?	YES
165. Do you think you are in poor health?	YES
166. Have you gained more than five pounds in the last six months?	YES
167. Have you lost more than ten pounds in the last six months?	YES
168. Are you on a weight reduction diet?	YES
169. Are you on any other type of medical diet?	YES
170. Have you had a fever or temperature of greater than 100 degrees in the past two weeks?	YES
171. Have you traveled extensively outside the USA or Canada?	YES
172. Have you ever been married?	YES
173. One time	YES
174. Two times	YES
175. Three times	YES
176. Four times	YES
177. More than four times	YES
178. Have you attended more than two colleges?	YES
179. More than two as an undergraduate	YES
180. More than three as an undergraduate	YES
181. More than three as an undergraduate and post graduate	YES
182. Describe the type of exercise you regularly obtain.	
183. Strenuous (Running, swimming, cycling, etc.)	YES
184. Mild (Walking some distance)	YES
185. No special exercise	YES
186. Have you changed jobs more than twice in the past three years?	YES
187. Have you stayed in one job over five years?	YES
188. Do you include milk, eggs, cheese, butter, fatty meats and other saturated fats in your daily diet?	YES
<b>Are you allergic to any of the following medicines?</b>	
189. Penicillin	YES
190. Sulfa	YES
191. Antibiotics (not mentioned above)	YES
192. Barbiturates	YES

- 193. Codeine YES
- 194. Demerol YES
- 195. Morphine YES
- 196. Digitalis Preparations YES
- 197. Aspirin YES
- 198. Any other medicine or drug YES

**Are you allergic to any of the following items?**

- 199. Eggs YES
- 200. Milk YES
- 201. Feathers YES
- 202. Soap YES
- 203. Detergents YES
- 204. Cosmetics YES

- 205. Have you ever smoked cigarettes? YES

**For how many years of your life have you smoked?**

- 206. Less than 10 years? YES
- 207. 10 – 20 years? YES
- 208. More than 20 years? YES

**How much do you smoke at the present time?**

- 209. Nothing YES
- 210. Less than 1 pack per day YES
- 211. One pack per day YES
- 212. One or two packs a day YES
- 213. More than two packs a day YES

- 214. Have you stopped smoking cigarettes? YES

**If so, did you stop**

- 215. within the last year? YES
- 216. within the last two years? YES
- 217. longer than five years ago? YES
- 218. from five to ten years ago? YES

- 219. Before you stopped smoking, did you smoke more than a pack a day? YES

- 220. Do you smoke cigars? YES

- 221. Do you smoke a pipe? YES

- 222. Do you usually drink four or more glasses of beer a day? YES

- 223. Do you drink alcoholic beverages? YES

**How much do you drink during an average day?**

- 224. Less than 1 drink a day YES
- 225. A drink or two a day YES
- 226. More than three drinks a day YES
- 227. A pint or more a day YES

- 228. Do you ever drink alcohol in the morning? YES

- 229. Do you drink more than two cups of coffee a day? YES

230. Do you drink milk every day? YES
231. Do drink more than 3 glasses of milk a day? YES
232. Do you eat fruit every day? YES
- Have you had any of the following problems in the last year?**
233. Double vision YES X
234. Blurred or cloudy eyesight which lasted more than a few minutes YES X
235. Pain in the eyeball which lasted more than a few minutes YES X
236. Poor vision YES X
237. Do you wear eyeglasses? YES
238. Do you have any difficulty hearing? YES
239. Do you often hear buzzing or ringing in your ears? YES
240. Do you have drainage other than wax from either ear? YES
241. Is your nose stuffy or runny all year round? YES
242. Are you troubled by sinus pain or ache above or below either eye? YES
243. Have you had excessive trouble with your teeth? YES
244. Do your gums bleed frequently? YES
245. Do you wear false dentures (teeth)? YES
246. Is your tongue frequently sore or sensitive? YES
247. Do you have a persistent sore or rough area around your lips, mouth, or on your face? YES
248. Have you had more than two bad nosebleeds in the past six months? YES
249. Has your voice changed or become hoarse in the past year? YES
250. Have you noticed any enlarged glands or nodes during the past year? YES
- In which part of your body were the enlarged glands located?
251. Neck YES
252. Armpit YES
253. Groin YES
254. Some other parts? YES
255. During the past year, have you been told that you were anemic or that you had low blood? YES X
256. Do you bleed for a very long time when you injure yourself or after you have a tooth extracted or have surgery? YES

257. Do you get bruises (black and blue marks) very easily? YES
258. Do you frequently develop pains or cramps in the calves of your legs while walking? YES
259. Do these pains make you stop walking? YES
260. Do the pains go away if you rest for a few minutes? YES
261. Do your fingers usually become painful, numb, white or blue when they get chilled? YES
262. Has the skin on your lower legs become dark in color? YES
263. Do you often have swelling in both ankles? YES
264. During the past year, have you had episodes of pain, discomfort, tightness or pressure anywhere in the chest? YES
- Where is the pain or discomfort located?
265. In the middle of the chest under the breastbone? YES
266. On the left side only? YES
267. On the right side only? YES
268. On both sides? YES
269. Does the pain move to the left shoulder or arm? YES
- How often does it occur?
270. Less than once a month YES
271. Every two or three weeks YES
272. More than once a week YES
273. Every day YES
274. Is the pain severe? YES
275. Is the pain altered by breathing? YES
276. Is the pain altered by movement? YES
- Does the pain or discomfort come on after you have
277. Eaten a large meal? YES
278. Been doing strenuous work? YES
279. Been angry or excited? YES
280. Taken a deep breath? YES
281. Been bending over? YES
282. Been sleeping soundly in bed? YES
- With rest, does the pain or discomfort go away
283. immediately? YES
284. in less than five minutes? YES
285. in five to thirty minutes? YES
286. in more than thirty minutes? YES
287. resting does not relieve the pain? YES

288. Have you ever had an electrocardiogram (EKG) taken? YES X
289. Has a physician ever said your EKG was abnormal in any way? YES
290. Does your heart ever palpitate, race or flutter at times when you are not anxious or excited? YES
291. Does your heart ever beat two or three times and then skip a beat? YES
292. Do you find it necessary to sleep propped up (with extra pillows or in a chair) to help you breathe better? YES
- How long have you slept propped up?
293. For less than a month? YES
294. For a few months? YES
295. For about a year? YES
296. For more than a year? YES
297. Do you have a cough at the present time? YES
298. Has your present cough continued for more than a month? YES
299. Do you cough up sputum or phlegm? YES
300. Have you coughed up blood in the last two years? YES
- Do you get short of breathe under any of the following conditions?
301. When you climb a flight of stairs? YES
302. When you are asleep flat in the bed? YES
303. With limited exertion? YES
- During the past two years, have you heard wheezing or whistling sounds when you breathe?
304. Did the wheezing start less than six months ago? YES
305. Do you still get periods of wheezing? YES
306. Do you have sweating at night that drenches your bed clothes? YES
307. During the past five years, have you had any close contact with people who have tuberculosis? YES
308. In the last year, have you had a feeling of a lump in your throat when not eating? YES X
309. Over the last year, has it become difficult for you to swallow food or water? YES
310. Do you ever get heartburn or indigestion? YES
311. Every month or two YES
312. About once a month YES
313. Almost every day YES
314. Are you belching more often than in the past? YES
315. Is your abdomen more distended (blown up) now than formerly? YES

316. In the past year have you frequently had attacks of nausea or vomiting? YES
- How often does the nausea or vomiting occur?
317. About once a month YES
318. About once a week YES
319. Almost every day YES
320. During the past year, have you vomited up any blood or materials that look like coffee grounds? YES
321. Do you often get bad pains in your stomach or abdomen? YES
- Do the pains in your stomach or abdomen feel
322. Dull YES
323. Sharp YES
324. Crampy YES
325. Other kind of feeling YES
- Are the pains located
326. on the right side YES
327. on the left side YES
328. above the umbilicus (navel) YES
329. below the umbilicus (navel) YES
330. throughout the stomach or abdomen YES
- Do these pains occur
331. every day YES
332. every few days YES
333. every week or two YES
334. occasionally YES
- Do the pains come
335. Directly with or after eating a meal YES
336. One or two hours after eating YES
337. At no particular time YES
338. After eating fried or fatty foods YES
- Do these stomach pains
339. Become worse on bending or lying down YES
340. Keep you from falling asleep YES
341. Awaken you from sleep YES
- Are these pains relieved by
342. Taking milk, Tums, creams or antacids YES
343. Eating YES
344. A bowel movement YES
345. During the past six months, have you noticed a decrease in your appetite so you now have little interest in eating? YES
346. During the past year have you had any diarrhea, constipation or other problems with your bowel movements? YES

Do you have trouble with frequent	
347. Diarrhea (loose bowels)	YES
348. Constipation	YES
349. Rectal pain	YES
350. Straining with bowel movements	YES
351. During the last year, have you noticed that you must use laxatives more frequently than before?	YES
352. Do you have an urge for a bowel movement more than three a day with little stool resulting?	YES
353. During the past year, have you noticed bowel movements that were as black as tar or coal?	YES
354. Were you taking iron or vitamins at the time?	YES
355. During the past six months, have you noticed any blood in your bowel movements?	YES
356. During the past six months, have you had periods of diarrhea followed by periods of constipation?	YES
357. Do you normally have a problem with itching of your anus or your rectal area?	YES
In the past six months, have you had	
358. Pain, burning or stinging with urination	YES
359. Difficulty in starting to urinate	YES
360. Decrease in size of your urinary stream	YES
361. Blood in your urine	YES
362. Dark brown urine	YES
363. Do you wet your pants with coughing, sneezing, laughing or at other times when you do not wish to urinate?	YES
364. Does your urine come out in dribbles, rather than with a strong stream?	YES
365. Are there are times when you feel that you have to urinate but find that you cannot pass any urine?	YES
366. During the past three months, have you noticed more frequent urination?	YES
367. Do you get up more than once a night to urinate?	YES
368. Do you get up more than two times a night to urinate?	YES
How long have you been getting up this often to urinate	
369. For less than six months	YES
370. For six months to a year	YES
371. For more than a year	YES
372. Do you get all mixed up when you have to do things quickly?	YES

373. Do you usually have a problem in falling asleep or staying asleep at night? YES
374. Do you get scared when you are alone at night? YES
375. Do become scared for no particular reason? YES
376. Are you frequently keyed up or jittery about things? YES
377. In the past two years, have ever gotten nervous or upset about anything? YES
378. In general, do you tend to be anxious or nervous? YES
379. Do you think that any symptoms or complaints which you may have may be related to your being anxious or nervous? YES
380. Do you feel that your life would be happier if you had some medicine to take whenever you feel nervous or upset? YES
381. Do you find that you develop a pain in the back of your neck or head when you are tense, upset or nervous? YES
382. Do you feel that other people are doing things to hurt you? YES
383. Do you frequently explode over things which are really not very important? YES
384. Are you a very shy person? YES
385. Do you find that your hands are often trembling? YES
386. Do you find you are often depressed or worried about something? YES
387. Do you often lie awake at night? YES
388. Do you find that you cry almost every day? YES
389. During the past year, have you noticed that you have lost interest in sexual activity? YES
390. Are you tired in the morning after getting a good night's sleep? YES
391. Have you ever sought professional help because of a nervous, mental or emotional problem? YES
392. Have you ever had persistent numbness or weakness in any part of your body? YES
393. Has any part of your body ever been paralyzed? YES
394. Have you ever experienced any unsteadiness in your walking or balance? YES
395. Have you ever been knocked unconscious? YES

396. Has your handwriting changed recently? YES
397. Have you noticed any tremor or shaking of your hands or any other parts of your body? YES
398. Do you have frequent headaches? YES
399. Are these headaches severe enough to go to bed? YES
- Do these headaches occur
400. more than once a month YES
401. less than once a month YES
402. more than once a week YES
- Are these headaches usually
403. located in the frontal portion of the head YES
404. located in the back portion of the head YES
405. located in the sinus area YES
406. Have you had an episode of fainting, passing out or being knocked unconscious in the past year? YES
- Was this episode of fainting, passing out or being knocked unconscious caused by
407. an injury to your head YES
408. drinking too much alcohol YES
409. some upsetting reason such as an accident, shock, fright, etc. YES
- How many such episodes have you had in the past year
410. one YES
411. more than one YES
- How long were you unconscious or how long are you usually unconscious with such an episode?
412. less than 5 minutes YES
413. more than 30 minutes YES
414. don't know how long YES
- During the past year, have you had any of the following?
415. Speech becoming slurred YES
416. Difficulty writing clearly as you used to YES
417. Difficulty in buttoning your clothes YES
418. During the past year, have you noticed unusual weakness in an arm or leg? YES
419. Do you get pain in your joints or bones? YES
420. Does this pain affect more than one joint or bone? YES
421. Does a mild pain medicine such as aspirin relieve the pain? YES

422. Is the pain occasionally severe enough to prevent your moving an arm or leg? YES
423. Do you usually get stiffness in your joints when you awaken in the morning? YES
424. Do you ever get back pains which are so severe that they prevent you from doing your normal work? YES
- Are the pains
425. In your lower back YES
426. In your upper back YES
427. In your neck YES
428. Do the pains pass from your lower spine down to the back of either or both legs? YES
- How often do you get the pains?
429. Every day YES
430. Some time each week YES
431. After doing heavy work YES
432. Rarely YES
433. Do your feet trouble you in any way? YES
434. Do you wear special shoes? YES
435. Can you lift as well as you could five years ago? YES
436. Are your arms nearly equal in strength? YES
437. Are your legs nearly equal in strength? YES
438. Have you ever had a neck injury including a "Whiplash"? YES
439. Have you ever had bursitis or pain in the shoulder or hip? YES

**ANSWER ONLY IF MALE!**

- Have you ever had any of the following?
440. Prostatitis or infected prostate gland? YES
441. Enlarged prostate gland YES
442. Cyst or tumor of your testicles YES
443. Prostate surgery YES
444. Inability to have an erection? YES
445. Have you had or do you have sores on the Penis? YES
446. Have you had or do you have discharge from the Penis? YES
447. Have you had or do you have swelling or tenderness of scrotum or testicles? YES
448. Have you had or do you have any problem with infertility or impotence? YES

449. Have you been circumcised? YES
450. Have you ever had an instrument (Cystoscope, etc.) passed into the bladder? YES
- In the male breast, have you ever had
451. Lumps? YES
452. Tenderness? YES
453. Discharge? YES

**ANSWER ONLY IF FEMALE!**

- Have you ever had any of the following operations?
454. "D and C" (scraping of the womb) YES
455. Cesarean section ("C" section) YES
456. Removal of ovary only YES
457. Partial hysterectomy (removal of the womb) YES
458. Total hysterectomy (removal of the womb, ovaries, cervix, etc.) YES
459. Simple breast surgery YES
460. Removal of a breast (Mastectomy) YES
- When did you last have a cervical "PAP" smear?
461. In the last two years YES
462. More than two years ago YES
463. In the past year, have you noticed any discharge from the breast nipple other than when you were pregnant? YES
464. Have you ever noticed any lumps in your breast? YES
465. Is the lump now present? YES
- Is the lump(s) located in
466. left breast only YES
467. right breast only YES
468. both breasts YES
- For how long have these lumps been present?
469. less than six months YES
470. for six months or more YES
471. Are your menstrual periods irregular in any way? YES
472. Have your menstrual periods stopped? YES
473. Are you pregnant? YES
474. During the past year, have you had a marked change in the type or timing of your menstrual periods? YES
475. During the past year, have you had an irregular vaginal bleeding that was not a period? YES
476. During the past year, have you had spotting of blood between periods? YES
477. Do you have to stay home because of your periods? YES

478. Do you use medication for menstrual pain? YES
479. Do you take hormones? YES
480. Have you taken hormones, but discontinued? YES
481. Do you take birth control pills? YES
482. Have you ever changed brands of birth control pills? YES
483. Have you taken birth control pills but stopped? YES
484. Have you had an IUD, such as loop, spring, diaphragm, etc. inserted? YES
485. If not still in place, did it fall out? YES
486. If not still in place, was it removed? YES
487. Do you use any other method to prevent pregnancy? YES
488. Do you think you are pregnant now? YES
489. Have you ever had an abnormal "PAP" Cancer Smear? YES

**AUDIOMETRIC HISTORY**

490. Have you been exposed to loud noises recently? YES
491. Was there noise exposure on your previous jobs? YES
492. In the military, did you ever have exposure to gunfire, jet engines or other excessive noise? YES
493. Have you ever had or do you have:
- (a) ear infection YES
  - (b) ear drainage YES
  - (c) ear injury: left ear YES
  - right ear YES
  - (d) ear surgery: left ear YES
  - right ear YES
  - (e) excessive ringing in ears YES
  - (f) head injury without unconsciousness YES
  - (g) hearing problems from medications YES
494. Do you have significant exposure to any of the following without ear protection outside your employment
- (a) use of firearms YES
  - (b) motor cycles YES
  - (c) power tools YES
  - (d) farm machinery YES
  - (e) speed boats YES
  - (f) rock music bands YES
495. Are you currently under a doctors care for hearing problems? YES

