MEDICAL QUESTIONNAIRE- confidential

GENERAL INFORMATION

1. WHAT IS YOUR NAME? _____

2. WHAT IS YOUR ADDRESS? _____

   _____

3. WHAT IS YOUR HOME PHONE NUMBER? _____

4. WHAT IS YOUR BIRTH DATE? _____

5. WHAT IS YOUR GENDER? □ MALE □ FEMALE

6. WHAT IS YOUR RACE?

   - □ AFRICAN AMERICAN
   - □ ASIAN
   - □ HISPANIC
   - □ WHITE
   - □ OTHER _____

INFORMATION ABOUT YOUR CURRENT WORK

7. WHO IS YOUR CURRENT EMPLOYER? _____

   A. WHAT YEAR DID YOU START WORKING HERE? _____

8. WHAT IS YOUR CURRENT JOB? _____

   A. WHAT IS YOUR CURRENT DEPARTMENT? _____

   B. WHAT YEAR DID YOU START WORKING IN THIS DEPARTMENT? _____

   C. WHAT ARE YOUR JOB DUTIES? _____

MEDICAL INFORMATION

9. HAVE YOU SEEN A DOCTOR FOR SHORTNESS OF BREATH? □ NO □ YES

   A. IF YES, WHAT YEAR DID YOU FIRST SEE A DOCTOR? _____

10. HAVE YOU SEEN A DOCTOR FOR SINUS PROBLEMS? □ NO □ YES

    A. IF YES, WHAT YEAR DID YOU FIRST SEE A DOCTOR? _____

11. HAVE YOU EVER SEEN A DOCTOR FOR SKIN RASH? □ NO □ YES

A. IF YES, WHAT YEAR DID YOU FIRST SEE A DOCTOR? _____

12. DO YOU BRING UP MUCUS MOST DAYS OF THE WEEK (4 OUT OF 7 DAYS) FOR 3 OR MORE MONTHS STRAIGHT? □ NO □ YES

A. IF YES, WHAT YEAR DID THIS START? _____

13. HAVE YOU EVER HAD ASTHMA? □ NO □ YES

IF YES:

A. DO YOU STILL HAVE ASTHMA? □ NO □ YES

B. WAS IT CONFIRMED BY A DOCTOR? □ NO □ YES

C. WHAT AGE DID YOUR ASTHMA START? _____

D. IF YOU NO LONGER HAVE ASTHMA, WHAT AGE DID IT STOP? _____

E. DO YOU CURRENTLY REQUIRE MEDICINE OR TREATMENT FOR ASTHMA? □ NO □ YES

1) IF YES, WHAT TYPES OF ASTHMA MEDICINE? _____

_____

14. **BEFORE** WORKING FOR YOUR CURRENT EMPLOYER, DID YOU EVER HAVE:

□ NO □ YES ALLERGIES
□ NO □ YES HAY FEVER
□ NO □ YES ECZEMA (SKIN RASH)

15. DID/DO ANY BLOOD RELATIVES HAVE: □ NO □ YES
IF YES, check all that apply:

	FATHER	MOTHER	BROTHER(S)	SISTER(S)
ALLERGIES	□	□	□	□
HAY FEVER	□	□	□	□
ASTHMA	□	□	□	□
ECZEMA	□	□	□	□

16. DO OR DID YOU EVER SMOKE CIGARETTES? □ NO □ YES

IF YES:

A. HOW MANY PACKS PER DAY? _____

B. HOW OLD WERE YOU WHEN YOU STARTED SMOKING? _____

C. HOW OLD WERE YOU WHEN YOU QUIT SMOKING? _____

D. DO YOU CARRY CIGARETTES IN THE WORK PLACE? □ NO □ YES

17. **WHEN YOU ARE AT WORK**, HOW OFTEN DO ANY OF THE SYMPTOMS LISTED BELOW BOTHER YOU? REMEMBER, THIS IS AT WORK, *NOT WHEN YOU ARE SICK OR HAVE A COLD.*

Circle the number that corresponds to how often you are bothered by each symptom AT WORK.

	NEVER	SELDOM	MONTHLY	WEEKLY	DAILY	YEAR STARTED	PLANT AREA
NASAL STUFFINESS	1	2	3	4	5		
RUNNY NOSE	1	2	3	4	5		
TEARING, BURNING EYES	1	2	3	4	5		
EYE REDNESS	1	2	3	4	5		
FACE SWELLING	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, SWEATS	1	2	3	4	5		
CHILLS, SHIVERING	1	2	3	4	5		
ACHE ALL OVER	1	2	3	4	5		
UNUSUAL TIREDNESS	1	2	3	4	5		

18. DID YOU REPORT ANY OF THE ABOVE SYMPTOMS TO YOUR SUPERVISOR? □ NO □ YES

19. DID YOU SEEK MEDICAL CARE FROM YOUR COMPANY FOR ANY OF THE ABOVE SYMPTOMS? □ NO □ YES

20. IN THE PAST YEAR, ARE THERE PEOPLE WHO NO LONGER WORK HERE BECAUSE OF A BREATHING PROBLEM? □ NO □ YES

IF YES, HOW MANY PEOPLE? _____

21. ARE THERE ANY OTHER HEALTH CONCERNS YOU WOULD LIKE TO BRING TO OUR ATTENTION?

_____

My participation in the Michigan Department of Licensing and Regulatory Affairs Medical Questionnaire is voluntary. The Department will use this information for purposes of assessing the presence of occupational hazards at this facility, and no information which identifies me will be released or published. There are no penalties if I decline to participate. I may end my participation at any time and I may refuse to answer individual questions or provide my name. Staff from the Michigan Department of Licensing and Regulatory Affairs or Michigan State University may contact me for additional information or clarification.

Signature: _____ Date: _____