

## HAZWOPPER Questionnaire

Your employer must allow you to answer the 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 you should bring this completed form with you when you are scheduled for your physical. The health care professional will review this questionnaire before your physical.

Identification			
Employee Name: _____			
Social Security Number:           -           -	Job: _____		
Date of birth (XX,XX,XXXX): _____	Height: _____	ft. _____	in. _____
Age: _____	Employer: _____		
Weight: _____ lbs	Sex (circle one):   Male   Female		

### Medical History

1. Have you ever been in the hospital as a patient (circle one)?   Yes | No
  - a. If yes, what kind of problem were you having? \_\_\_\_\_
2. Have you ever had any kind of operation (circle one)?   Yes | No
  - a. If yes, what kind? \_\_\_\_\_
3. Do you take any kind of medicine regularly (circle one)?   Yes | No
  - a. If yes, what kind? \_\_\_\_\_
4. Are you allergic to any drugs, food, or chemicals (circle one)?   Yes | No
  - a. If yes, what kind of allergy is it? \_\_\_\_\_
    - i. What causes the allergy? \_\_\_\_\_
5. Have you ever been told that you have asthma, hayfever, or sinusitis (circle one)?   Yes | No
6. Have you ever been told that you have emphysema, bronchitis, or any other respiratory problems (circle one)?   Yes | No
7. Have you ever been told that you had cancer (circle one)?   Yes | No
8. Have you ever been told that you had hepatitis (circle one)?   Yes | No
9. Have you ever been told that you had cirrhosis (circle one)?   Yes | No
10. Have you ever had arthritis joint pain (circle one)?   Yes | No
11. Have you ever been told that you had high blood pressure (circle one)?   Yes | No
12. Have you ever had a heart attack or heart trouble (circle one)?   Yes | No

**Continue**

## Occupational History

1. How long have you worked for your present employer? \_\_\_\_\_
2. What jobs have you held with this employer? Include job title and time in each job:  
\_\_\_\_\_
3. In each of these jobs, how many hours a day were you exposed to chemicals?  
\_\_\_\_\_
4. What chemicals have you worked with most of the time?  
\_\_\_\_\_
5. Have you ever noticed any type of skin rash you felt was related to your work(circle one)? Yes | No
6. Have you ever noticed that any kind of chemical makes you cough (circle one)? Yes | No
  - a. Wheeze (circle one)? Yes | No
  - b. Become short of breath or cause your chest to become tight (circle one)? Yes | No
7. Are you exposed to any dust or chemicals at home (circle one)? Yes | No
  - a. If yes, explain: \_\_\_\_\_
8. In other jobs, have you ever had exposure to:
  - a. Wood dust (circle one)? Yes | No
  - b. Nickel or chromium (circle one)? Yes | No
  - c. Silica (foundry, sand blasting) (circle one)? Yes | No
  - d. Arsenic or asbestos (circle one)? Yes | No
  - e. Organic solvents (circle one)? Yes | No
  - f. Urethane foams (circle one)? Yes | No

## Miscellaneous

1. Do you smoke (circle one)? Yes | No
  - a. If yes, how much and for how long: \_\_\_\_\_
  - b. Pipe (circle one)? Yes | No
  - c. Cigars (circle one)? Yes | No
  - d. Cigarettes (circle one)? Yes | No
2. Do you drink alcohol in any form (circle one)? Yes | No
  - a. If so, how much, how long, and how often: \_\_\_\_\_
3. Do you wear glasses or contact lenses (circle one)? Yes | No
4. Do you get any physical exercise other than that required to do your job (circle one)? Yes | No
  - a. If yes, explain: \_\_\_\_\_
5. Do you have any hobbies or "sidejobs" that require you to use chemicals, such as furniture stripping, sand blasting, insulation or manufacture of urethane foam, furniture, etc(circle one)? Yes | No
  - a. If so, please describe, giving type of business or hobby, chemicals used and length of exposure: \_\_\_\_\_  
\_\_\_\_\_

Continue

## Symptoms Questionnaire

1. Do you ever have shortness of breath (circle one)? Yes | No
  - a. If yes, do you have to rest after climbing several flights of stairs (circle one)? Yes | No
  - b. If yes, if you walk on the level ground with people your own age, do you walk slower than they do (circle one)? Yes | No
  - c. If yes, you walk slower than normal pace, do you have to limit the distance that you walk (circle one)? Yes | No
  - d. If yes, do you have to stop and rest while bathing or dressing (circle one)? Yes | No
2. Do you cough as much as three months out of the year (circle one)? Yes | No
  - a. If yes, have you had this cough for more than two years (circle one)? Yes | No
  - b. If yes, do you ever cough anything up from the chest (circle one)? Yes | No
3. Do you ever have a feeling of smothering, unable to take a deep breath, or tightness in your chest (circle one)? Yes | No
  - a. If yes, do you notice this on any particular day of the week (circle one)? Yes | No
    - i. If yes, what day of the week: \_\_\_\_\_
    - ii. If yes, do you notice that this occurs at any particular place (circle one)? Yes | No
    - iii. If yes, where: \_\_\_\_\_
    - iv. If yes, do you notice that this is worse after you have returned to work after being off for several days (circle one)? Yes | No
4. Have you noticed any wheezing in your chest (circle one)? Yes | No
  - a. If yes, is this only with colds or other infections (circle one)? Yes | No
  - b. Is this caused by exposure to any kind of dust or other materials (circle one)? Yes | No
    - i. If yes, what kind: \_\_\_\_\_
5. Have you ever noticed any dizziness (circle one)? Yes | No
  - a. If yes, when and how often: \_\_\_\_\_
6. Have you noticed any headaches (circle one)? Yes | No
  - a. If yes, when and how often: \_\_\_\_\_
7. Have you noticed any blurred or double vision (circle one)? Yes | No
  - a. If yes, when and how often: \_\_\_\_\_
8. Have you noticed any uncoordination (circle one)? Yes | No
  - a. If yes, when and how often: \_\_\_\_\_
9. Have you noticed any mental confusion, anxiety or giddiness (circle one)? Yes | No
  - a. If yes, when and how often: \_\_\_\_\_
10. Have you noticed any flushed skin(circle one)? Yes | No
  - a. If yes, when and how often: \_\_\_\_\_
11. Have you noticed any tremors (circle one)? Yes | No
  - a. If yes, when and how often: \_\_\_\_\_
12. Have you noticed any nausea or vomiting (circle one)? Yes | No
  - a. If yes, when and how often: \_\_\_\_\_
13. Have you noticed any fatigue (circle one)? Yes | No
  - a. If yes, when and how often: \_\_\_\_\_

Continue

Signature:	
Address:	
Phone Number:	
<b>Official Use Only</b>	
Reviewed by:	SafeWorks Illinois Personal