



champaign	decatur	mobile health services	chicago
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P: 217.356.6150	P: 217.425.2732	P: 217.864.6000	P: 312.361.2104
F: 217.356.7167	F: 217.425.4778	F: 217.864.6111	F: 312.942.1517

HAZWOPPER QUESTIONNAIRE

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 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: _____

Birth date: Month _____ Day _____ Year _____

Height: _____ ft. _____ in.

Age: _____

Weight: _____ lbs.

Sex: Male or Female

Employer: _____

Medical History

1. Have you ever been in the hospital as a patient? Yes or No
If yes, what kind of problem were you having? _____
2. Have you ever had any kind of operation? Yes or No
If yes, what kind? _____
3. Do you take any kind of medicine regularly? Yes or No
If yes, what kind? _____
4. Are you allergic to any drugs, food, or chemicals? Yes or No
If yes, what kind of allergy is it? _____
What causes the allergy? _____
5. Have you ever been told that you have asthma, hayfever, or sinusitis? Yes or No
6. Have you ever been told that you have emphysema, bronchitis, or any other respiratory problems? Yes or No

7. Have you ever been told that you had cancer? Yes or No
8. Have you ever been told that you had hepatitis? Yes or No
9. Have you ever been told that you had cirrhosis? Yes or No
10. Have you ever had arthritis joint pain? Yes or No
11. Have you ever been told that you had high blood pressure? Yes or No
12. Have you ever had a heart attack or heart trouble? Yes or No

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? Yes or No
6. Have you ever noticed that any kind of chemical makes you cough? Yes or No
Wheeze? Yes or No
Become short of breath or cause your chest to become tight? Yes or No
7. Are you exposed to any dust or chemicals at home? Yes or No
Is yes, explain? _____
8. In other jobs, have you ever had exposure to:
Wood dust? Yes or No
Nickel or chromium? Yes or No
Silica (foundry, sand blasting)? Yes or No
Arsenic or asbestos? Yes or No
Organic solvents? Yes or No
Urethane foams? Yes or No

Miscellaneous

1. Do you smoke? Yes or No
If yes, how much and for how long? _____
Pipe? Yes or No
Cigars? Yes or No
Cigarettes? Yes or No
2. Do you drink alcohol in any form? Yes or No
If so, how much, how long, and how often? _____
3. Do you wear glasses or contact lenses? Yes or No
4. Do you get any physical exercise other than that required to do your job? Yes or No
If so, 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? Yes or No
If so, please describe, giving type of business or hobby, chemicals used and length of exposure. _____

Symptoms Questionnaire

1. Do you ever have shortness of breath? Yes or No
If yes, do you have to rest after climbing several flights of stairs? Yes or No
If yes, if you walk on the level with people your own age, do you walk slower than they do? Yes or No
If yes, you walk slower than a normal pace, do you have to limit the distance that you walk? Yes or No
If yes, do you have to stop and rest while bathing or dressing? Yes or No
2. Do you cough as much as three months out of the year? Yes or No
If yes, have you had this cough for more than two years? Yes or No
If yes, do you ever cough anything up from the chest? Yes or No
3. Do you ever have a feeling of smothering, unable to take a deep breath, or tightness in your chest? Yes or No
If yes, do you notice this on any particular day of the week? Yes or No
If yes, what day of the week? _____
If yes, do you notice that this occurs at any particular place? Yes or No
If yes, where? _____

If yes, do you notice that this is worse after you have returned to work after being off for several days? Yes or No

4. Have you noticed any wheezing in your chest? Yes or No

If yes, is this only with colds or other infections? Yes or No

Is this caused by exposure to any kind of dust or other materials? Yes or No

If yes, what kind? _____

5. Have you noticed any dizziness? Yes or No

If yes, when? _____

If yes, how often? _____

6. Have you noticed any headaches? Yes or No

If yes, when? _____

If yes, how often? _____

7. Have you noticed any blurred or double vision? Yes or No

If yes, when? _____

If yes, how often? _____

8. Have you noticed any uncoordination? Yes or No

If yes, when? _____

If yes, how often? _____

9. Have you noticed any mental confusion, anxiety or giddiness? Yes or No

If yes, when? _____

If yes, how often? _____

10. Have you noticed any flushed skin? Yes or No

If yes, when? _____

If yes, how often? _____

11. Have you noticed any tremors? Yes or No

If yes, when? _____

If yes, how often? _____

12. Have you noticed any nausea or vomiting? Yes or No

If yes, when? _____

If yes, how often? _____

13. Have you noticed any fatigue? Yes or No

If yes, when? _____

If yes, how often? _____

Employee Information

Employee Signature: _____

Address: _____

City, State, Zip: _____

Phone Number _____

Name of health care provider who reviewed form:
