McLaren
OCCUPATIONAL HEALTH
& CONVENIENT CARE

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PULMONARY QUESTIONNAIRE

1. Name _____
2. Social Security # _____
3. Present Occupation _____
4. Plant _____
5. Address _____
6. _____ Zip Code _____
7. Telephone Number _____
8. Interviewer _____
9. What is your marital status? 1. Single ____ 3. Widowed ____
   2. Married ____ 4. Separated/Divorced ____

10. **OCCUPATIONAL HISTORY**

A. In the past year, did you work full time (30 hours per week or more) for 6 months or more? Yes ____ No ____

IF YES TO 10A:

B. In the past year, did you work in a dusty job? 1. Yes ____ 2. No ____ 3. Does not apply ____

C. Was dust exposure: 1. Mild ____ 2. Moderate ____ 3. Severe ____

D. In the past year, were you exposed to gas or chemical fumes in your work? 1. Yes ____ 2. No ____

E. Was exposure: 1. Mild ____ 2. Moderate ____ 3. Severe ____

F. In the past year, what was your: 1. Job/Occupation? _____
   2. Position/Job title? _____

11. Do you consider yourself to be in good health? 1. Yes ____ 2. No ____

A. If NO, state reason _____

B. In the past year, have you developed:

	YES	NO
Epilepsy?	____	____
Rheumatic Fever?	____	____
Kidney Disease?	____	____
Bladder Diabetes?	____	____
Diabetes?	____	____
Jaundice?	____	____
Cancer?	____	____

12. **CHEST COLDS AND CHEST ILLNESSES**

A. If you get a cold, does it “usually” go to your chest? (usually means more than half the time)

1. Yes ____ 2. No ____ 3. Don’t get colds____

13. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?

1. Yes ____ 2. No ____ 3. Does not apply____

IF YES TO 13:

A. Did you produce phlegm with any of these chest illnesses?

1. Yes ____ 2. No ____ 3. Does not apply ____

B. In the past year, how many such illness with (increased phlegm did you have which lasted a week or more?

Number of illnesses _____ No such illnesses _____

14. **RESPIRATORY SYSTEM**

In the past year have you had:

	YES or NO	Further Comment on Positive Answers
Asthma	_____	
Bronchitis	_____	
Hay Fever	_____	
Other Allergies	_____	
Pneumonia	_____	
Tuberculosis	_____	
Chest Surgery	_____	
Other Lung Problems	_____	
Heart Disease	_____	

Do you have:

Frequent colds	_____	
Chronic cough	_____	
Shortness of breath when walking or climbing one flight of stairs	_____	

Do you:

Wheeze	_____	
Cough up phlegm	_____	
Smoke cigarettes _____	Packs per day _____	How many years _____

Date _____ Signature _____