

# Company Care

5000 N. 26th Street, Suite 200, Lincoln, NE 68521  
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## Part 2 PERIODIC MEDICAL QUESTIONNAIRE

1. NAME: \_\_\_\_\_
2. SOCIAL SECURITY # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_
3. CLOCK NUMBER \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_
4. PRESENT OCCUPATION: \_\_\_\_\_
5. PLANT: \_\_\_\_\_
6. ADDRESS: \_\_\_\_\_
7. \_\_\_\_\_  
(Zip Code)
8. TELEPHONE NUMBER \_\_\_\_\_
9. INTERVIEWER \_\_\_\_\_
10. DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_
11. What is your marital status?  
1. Single \_\_\_\_      4. Separated \_\_\_\_  
2. Married \_\_\_\_      5. Divorced \_\_\_\_  
3. Widowed \_\_\_\_
12. OCCUPATIONAL HISTORY
- 12A. In the past year, did you work full time (30 hours per week or more) for 6 months or more?  
1. Yes \_\_\_\_      2. No \_\_\_\_  
IF YES TO 12A:
- 12B. In the past year, did you work in a dusty job?  
1. Yes \_\_\_\_      2. No \_\_\_\_  
3. Does not Apply \_\_\_\_
- 12C. Was dust exposure:    1. Mild \_\_\_\_    2. Moderate \_\_\_\_    3. Severe \_\_\_\_
- 12D. In the past year, were you exposed to gas or chemical fumes in your work?  
1. Yes \_\_\_\_      2. No \_\_\_\_

12E. Was exposure: 1. Mild \_\_\_ 2. Moderate \_\_\_ 3. Severe \_\_\_

12F. In the past year,  
what was your: 1. Job/occupation? \_\_\_\_\_  
2. Position/job title? \_\_\_\_\_

13. RECENT MEDICAL HISTORY

13A. Do you consider yourself to  
be in good health? Yes \_\_\_ No \_\_\_

If NO, state reason \_\_\_\_\_

13B. In the past year, have you  
developed:

	Yes	No
Epilepsy?	___	___
Rheumatic fever?	___	___
Kidney disease?	___	___
Bladder disease?	___	___
Diabetes?	___	___
Jaundice?	___	___
Cancer?	___	___

14. CHEST COLDS AND CHEST ILLNESSES

14A. If you get a cold, does it "usually" go to your chest?  
(usually means more than 1/2 the time)

1. Yes \_\_\_ 2. No \_\_\_  
3. Don't get colds \_\_\_

15A. 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 15A:

15B. Did you produce phlegm with any  
of these chest illnesses?

1. Yes \_\_\_ 2. No \_\_\_  
3. Does Not Apply \_\_\_

15C. In the past year, how many such  
illnesses with (increased) phlegm  
did you have which lasted a week  
or more?

Number of illnesses \_\_\_  
No such illnesses \_\_\_

16. RESPIRATORY SYSTEM

In the past year have you had:

	Yes or No	Further Comment on Positive Answers
Asthma	_____	
Bronchitis	_____	
Hay Fever	_____	
Other Allergies	_____	

	Yes or No	Further Comment on Positive Answers
Pneumonia	_____	
Tuberculosis	_____	
Chest Surgery	_____	
Other Lung Problems	_____	
Heart Disease	_____	

Do you have:

	Yes or No	Further Comment on Positive Answers
Frequent colds	_____	
Chronic cough	_____	
Shortness of breath when walking or climbing one flight or stairs	_____	
Do you:		
Wheeze	_____	
Cough up phlegm	_____	
Smoke cigarettes	_____	Packs per day _____ How many years _____

**Date** \_\_\_\_\_

**Signature** \_\_\_\_\_