

Interview Date: _____
Interviewer's Name: _____
Clearance: Q _____ L _____

UNITED STATES DEPARTMENT OF ENERGY BERYLLIUM WORKER ENHANCED MEDICAL SURVEILLANCE PROGRAM

GENERAL INFORMATION

NAME: _____ / _____ / _____
(Please print) First M.I. Last

ADDRESS: _____ / _____
Street Apt. #

_____ / _____ / _____
City State Zip Code

TELEPHONE (with area code): Home (____) _____ Work (____) _____

SOCIAL SECURITY #: _____ -- _____ -- _____

BADGE #: _____

DATE OF BIRTH: _____ / _____ / _____
Month Day Year

SEX: Male _____ Female _____

RACE: White (non-Hispanic) _____ Black (non-Hispanic) _____
Hispanic _____ American Indian _____
Asian _____ Other _____

LAST YEAR OF SCHOOL COMPLETED:

Grade School: ___01 ___02 ___03 ___04 ___05 ___06 ___07 ___08
High School: ___09 ___10 ___11 ___12
College: ___13 (Fresh) ___14 (Soph) ___15 (Jr) ___16 (Sr)
___17 (Masters) ___18 [Doctorate (Ph.D., M.D., etc.)]

TRADE SCHOOL: ___Yes ___No

ARE YOU CURRENTLY:

___ Employed (full-time)? ___ Non-Employed?
___ Employment Location _____ ___ On medical disability leave?
___ Retired?

OCCUPATIONAL HISTORY

EXAMPLE

2.1. Beginning with your very first full-time job, please complete the following for all jobs that you have ever held. (An example has been included for you on page 2. Begin listing your employers on page 3.) Please list any chemicals or materials you consider to be potentially dangerous or toxic that you worked with or worked around in any of these jobs. If more lines are needed for job titles and job responsibilities, please continue them at the bottom of the page. List your next employer on the next page. Please list only one employer per page, but you may list several job titles for each employer. Five pages for five separate employers are provided. In all instances when the employer is a Department of Energy (DOE) facility (Oak Ridge or elsewhere) **DO NOT** complete the section at the bottom of the page "Other dangerous or toxic chemicals or materials used in these jobs." The interviewer will discuss this section with you.

0. Employer (Company, agency, or institution)		Type of company, agency, or institution.			
Williams Lumber Co.		Lumber and Building Supplies			
Location of company, agency, or institution. (If a branch of the military service, state "multiple sites" for location.)		Years from	SIC Code (to be entered by ORISE):		
City Atlanta State GA		19 52 to 19 62			
Job titles (or job classifications)	Major job activity or responsibility (please be brief)	Did these activities or responsibilities involve beryllium? (Circle answer.)	Were these activities performed in a building where beryllium was in use? (Circle answer.)	In performing these activities, have you walked through a building where beryllium was in use?	SOC CODE (to be entered by ORISE)
a) Sales	a) Sold Paint & Supplies	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	
b) _____	b) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	
c) _____	c) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	
d) _____	d) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	
e) _____	e) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	
Other dangerous or toxic chemicals or materials used in these jobs: Solvents and paint thinners					

If more pages are needed, either make extra copies while the page is blank, or provide the same information on a plain sheet of paper.

OCCUPATIONAL HISTORY

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Location of company, agency, or institution. (If a branch of the military service, state "multiple sites" for location.)		Years from	SIC Code (to be entered by ORISE):		
City	State	19	to 19		
Job titles (or job classifications)	Major job activity or responsibility (please be brief)	Did these activities or responsibilities involve beryllium? (Circle answer.)	Were these activities performed in a building where beryllium was in use? (Circle answer.)	In performing these activities, have you walked through a building where beryllium was in use?	SOC CODE (to be entered by ORISE)
a) _____	a) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
b) _____	b) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
c) _____	c) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
d) _____	d) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
e) _____	e) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
Other dangerous or toxic chemicals or materials used in these jobs:					

If more pages are needed, either make extra copies while the page is blank, or provide the same information on a plain sheet of paper.

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2. Employer (Company, agency, or institution)		Type of company, agency, or institution.			
Location of company, agency, or institution. (If a branch of the military service, state "multiple sites" for location.)		Years from	SIC Code (to be entered by ORISE):		
City	State	19	to 19		
Job titles (or job classifications)	Major job activity or responsibility (please be brief)	Did these activities or responsibilities involve beryllium? (Circle answer.)	Were these activities performed in a building where beryllium was in use? (Circle answer.)	In performing these activities, have you walked through a building where beryllium was in use?	SOC CODE (to be entered by ORISE)
a) _____	a) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
b) _____	b) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
c) _____	c) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
d) _____	d) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
e) _____	e) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
Other dangerous or toxic chemicals or materials used in these jobs:					

If more pages are needed, either make extra copies while the page is blank, or provide the same information on a plain sheet of paper.

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3. Employer (Company, agency, or institution)		Type of company, agency, or institution.			
Location of company, agency, or institution. (If a branch of the military service, state "multiple sites" for location.)		Years from	SIC Code (to be entered by ORISE):		
City	State	19	to 19		
Job titles (or job classifications)	Major job activity or responsibility (please be brief)	Did these activities or responsibilities involve beryllium? (Circle answer.)	Were these activities performed in a building where beryllium was in use? (Circle answer.)	In performing these activities, have you walked through a building where beryllium was in use?	SOC CODE (to be entered by ORISE)
a) _____	a) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
b) _____	b) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
c) _____	c) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
d) _____	d) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
e) _____	e) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
Other dangerous or toxic chemicals or materials used in these jobs:					

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4. Employer (Company, agency, or institution)		Type of company, agency, or institution.			
Location of company, agency, or institution. (If a branch of the military service, state "multiple sites" for location.)		Years from	SIC Code (to be entered by ORISE):		
City	State	19	to 19		
Job titles (or job classifications)	Major job activity or responsibility (please be brief)	Did these activities or responsibilities involve beryllium? (Circle answer.)	Were these activities performed in a building where beryllium was in use? (Circle answer.)	In performing these activities, have you walked through a building where beryllium was in use?	SOC CODE (to be entered by ORISE)
a) _____	a) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
b) _____	b) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
c) _____	c) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
d) _____	d) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
e) _____	e) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
Other dangerous or toxic chemicals or materials used in these jobs:					

If more pages are needed, either make extra copies while the page is blank, or provide the same information on a plain sheet of paper.

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5. Employer (Company, agency, or institution)		Type of company, agency, or institution.			
Location of company, agency, or institution. (If a branch of the military service, state "multiple sites" for location.)		Years from	SIC Code (to be entered by ORISE):		
City	State	19	to 19		
Job titles (or job classifications)	Major job activity or responsibility (please be brief)	Did these activities or responsibilities involve beryllium? (Circle answer.)	Were these activities performed in a building where beryllium was in use? (Circle answer.)	In performing these activities, have you walked through a building where beryllium was in use?	SOC CODE (to be entered by ORISE)
a) _____	a) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
b) _____	b) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
c) _____	c) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
d) _____	d) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
e) _____	e) _____	Yes No Don't Know	Yes No Don't Know	Yes No Don't Know	_____
Other dangerous or toxic chemicals or materials used in these jobs:					

If more pages are needed, either make extra copies while the page is blank, or provide the same information on a plain sheet of paper.

2.2. Have you ever worked with, worked around, or otherwise been exposed to any of the following substances? (Please circle one answer for each substance. Please leave Employer No./Job letter blank.) The interviewer will discuss that particular substance with you.

If you answer "Yes" to any substance, the interviewer will list number of the primary employer and job letter from Pages 3-7 where the exposure occurred.

Uranium	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Asbestos	1 - Yes	Emp. No./Job letter_____	2 - No	3 -Don't know
Silica	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Silicon carbide	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Vanadium	1 - Yes	Emp. No./Job letter_____	2 - No	3 -Don't know
Titanium	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Aluminum	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Cobalt	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Hard metal (Tungsten carbide dust)	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Nickel	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Chromium	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Zirconium	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know

2.3. Have you ever been employed in any of the following occupations? (Please circle one answer for each occupation.) Please leave Employer No./Job letter blank.) The interviewer will discuss that particular occupation with you.

If "Yes," please list number of that job from Pages 2 or 3.

Coal miner	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Asbestos worker	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Tunnel worker	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Sandblaster	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Silica or sand worker	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Quarry worker	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Welder	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Brazer	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know
Talc worker	1 - Yes	Emp. No./Job letter_____	2 - No	3 - Don't know

Name: _____

Interviewer's Name: _____

Clearance: Q _____ L _____

2.4. Beryllium Jobs (Interviewer to complete).

If you have never worked directly with beryllium, that is, where you used beryllium in your job, skip Sections 2.4 - 2.8, and go to Section 2.9.

Employer	Job title	Years in that job	Area (name or number of building or location)	Duty/activity/responsibility	Days/week	Hours/day	Weeks/Year	Type of beryllium material	Protective equipment	Other chemicals or materials used (liquids, gases, and solids)
		19 ____ to 19 ____								
		19 ____ to 19 ____								

2.4. **Beryllium Jobs** (Interviewer to complete).

Employer	Job title	Years in that job	Area (name or number of building or location)	Duty/activity/responsibility	Days/week	Hours/day	Weeks/Year	Type of beryllium material	Protective equipment	Other chemicals or materials used (liquids, gases, and solids)
		19 ____ to 19 ____								
		19 ____ to 19 ____								

BERYLLIUM SPECIFIC WORK HISTORY (Continued)

2.5. 1. Have you ever worked making rough parts by hot pressing?

1 - Yes 2 - No 3 - Don't know

2. Have you ever shaped parts on a machine or machine tool?

1 - Yes 2 - No 3 - Don't know

3. Have you ever worked changing fluorescent light bulbs in the years 1943-1949?

1 - Yes 2 - No 3 - Don't know 4 - Does not apply

2.6. Overall, how would you describe your past exposure to beryllium? (Please circle one answer.)

1 - None 3 - Moderate

2 - Minimal/Casual 4 - Heavy

2.7. Overall, when you were working with beryllium, was your exposure - (Please circle one answer.)

1 - Intermittent (a few times per week or month or year)?

2 - Constant (everyday)?

3 - Don't know?

BERYLLIUM SPECIFIC WORK HISTORY (Continued)

2.8. Have you ever worked where you were directly exposed to beryllium in any of the positions listed below?

Machinist		1 - Yes	2 - No	3 - Don't know
Cleaner		1 - Yes	2 - No	3 - Don't know
Machine tool specialist	1 -	Yes	2 - No	3 - Don't know
Janitor		1 - Yes	2 - No	3 - Don't know
Project engineer		1 - Yes	2 - No	3 - Don't know
Development engineer	1 -	Yes	2 - No	3 - Don't know
Process engineer		1 - Yes	2 - No	3 - Don't know
Electroplator		1 - Yes	2 - No	3 - Don't know
Maintenance craft				
Electrician	1 -	Yes	2 - No	3 - Don't know
Pipefitter		1 - Yes	2 - No	3 - Don't know
Outside machinist		1 - Yes	2 - No	3 - Don't know
Development technician		1 - Yes	2 - No	3 - Don't know
Supervisor		1 - Yes	2 - No	3 - Don't know
Utility operator		1 - Yes	2 - No	3 - Don't know
Filter crew		1 - Yes	2 - No	3 - Don't know
Fire inspector		1 - Yes	2 - No	3 - Don't know
Security inspector		1 - Yes	2 - No	3 - Don't know
Lab technician	1 -	Yes	2 - No	3 - Don't know
Radiographer		1 - Yes	2 - No	3 - Don't know
Material handler		1 - Yes	2 - No	3 - Don't know
Rigger		1 - Yes	2 - No	3 - Don't know
Dimensional inspector	1 -	Yes	2 - No	3 - Don't know
Assembly operator		1 - Yes	2 - No	3 - Don't know

Other (please specify)

_____		1 - Yes	2 - No	3 - Don't know
_____		1 - Yes	2 - No	3 - Don't know
_____		1 - Yes	2 - No	3 - Don't know
_____		1 - Yes	2 - No	3 - Don't know
_____		1 - Yes	2 - No	3 - Don't know
_____		1 - Yes	2 - No	3 - Don't know

BERYLLIUM SPECIFIC WORK HISTORY (Continued)

2.9. Have you ever been involved in any accident or unusual incident where you may have been exposed to very high levels of beryllium dusts or fumes? (Please circle one answer.)

1 - Yes 2 - No 3 - Don't know

If you answered "No" or "Don't know," please stop here.

If you answered "Yes" to question 2.9 above, please describe each incident and give approximate year or age at time of each incident in the box below.

<p>2.9.1.</p> <p>Incident 1: Age _____ (or year 19 _____) Description of incident</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Incident 2: Age _____ (or year 19 _____) Description of incident</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Incident 3: Age _____ (or year 19 _____) Description of incident</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

REL: _____ PARTIALLY REL: _____ UNREL: _____ NA: _____

Name: _____

SMOKING HISTORY

Please circle one answer to each of the following questions.

3.1. Have you smoked at least 100 cigarettes (5 packs) during your life? (1 pack = 20 cigarettes)

1 - Yes 2 - No

If you answered "Yes" to Question 3.1. above, please continue to answer the questions in this section.

If you answered "No" to Question 3.1., please go to Question 3.2.

3.1.1. About how old were you when you first started smoking cigarettes fairly regularly?

___ years old

3.1.2. Do you still smoke cigarettes?

1 - Yes 2 - No

If you answered "Yes" to Question 3.1.2. above, please answer the question in the box below.

**3.1.2.1. On average, how many cigarettes do you smoke per day
(in packs)?**

___ (Number of packs)

If you answered "No" to Question 3.1.2. above, please answer the question in the box below.

3.1.2.2. What year did you stop smoking cigarettes?

19_____ (year)

SMOKING HISTORY (Continued)

3.1.3. From the time you first smoked cigarettes regularly until now (or until the time you stopped smoking cigarettes) did you ever stop smoking cigarettes for a year or more, and then start smoking again?

1 - Yes 2 - No

If you answered "Yes" to Question 3.1.3. above, please answer the question in the box below. If you answered "No," please go to Question 3.1.4.

<p>3.1.3.1. What was the total number of years that you did not smoke?</p> <p>_____ (number of years)</p>
--

3.1.4. On average for the entire time that you smoked, how many cigarettes did you smoke per day (in packs)?

____ (number of packs)

3.1.5. When smoking, do you (or did you) inhale cigarette smoke?

1 - Not at all 3 - Moderately
2 - Slightly 4 - Deeply

3.1.6. Have you ever smoked cigarettes in an area where beryllium was in use? (Include beryllium processing.)

1 - Yes 2 - No

3.2. Have you ever lived with anyone who regularly smoked in your home?

1 - Yes 2 - No

If yes,

3.2.1. For how many years did you live with a regular smoker?

_____ (number of years)

SMOKING HISTORY (Continued)

3.2.2. Do you currently live with anyone who regularly smokes in your home?

1 - Yes 2 - No

3.2.3. If no, how many years has it been since someone who smoked regularly lived in you home?

_____ **(number of years)**

FAMILY MEDICAL HISTORY

Now, please think about your immediate family, that is, your natural (biological) family (including your mother, father, brothers, sisters, aunts, uncles, grandmothers, grandfathers).

4.1. Has any member of your biological family ever been told by a doctor that they have (or had) a chronic lung condition(s) such as:

- | | |
|--------------------------|-------------|
| Chronic bronchitis | Asthma |
| Emphysema | Lung cancer |
| Any other lung condition | |

1 - Yes 2 - No

(If you have questions about the above conditions, please ask the interviewer.)

If you answered "Yes" to Question 4.1. above, please complete the information in the box below. (An example is provided.) If you answered "No" to Question 4.1., please go to Question 4.2.

4.1.1.			
Member of Family	Lung Problem	Vital Status (Alive or Deceased)	Cause of Death (If Deceased)
1. Father	Lung cancer	Deceased	Heart attack
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

- 1 - Father
- 2 - Mother
- 3 - Sister
- 4 - Brother

- 5 - Aunts
- 6 - Uncles
- 7 - Grandmother
- 8 - Grandfather

- A - Alive
- D - Deceased
- U - Unknown

FAMILY MEDICAL HISTORY (Continued)

4.2. Has any member of your biological family ever been told by a doctor that they are/were allergic to bees, wasps, other insects, any animals, pollens, grass, trees, medication, or anything else?

1 - Yes 2 - No

If you answered "Yes" to Question 4.2. above, please provide the following information in the box below. (An example is provided.) If you answered "No" to Question 4.2., please go to Question 4.3.

4.2.1.			
<u>Member of Family</u>	<u>Allergic To</u>	<u>Season of Allergy</u>	
0. <u>Sister</u>	<u>Pollen</u>	Spring ___	Summer ___ Fall ___ Winter ___
0. <u>Brother</u>	<u>Bees</u>	Spring ___	Summer ___ Fall ___ Winter ___
1. _____		Spring ___	Summer ___ Fall ___ Winter ___
2. _____		Spring ___	Summer ___ Fall ___ Winter ___
3. _____		Spring ___	Summer ___ Fall ___ Winter ___
4. _____		Spring ___	Summer ___ Fall ___ Winter ___
5. _____		Spring ___	Summer ___ Fall ___ Winter ___

1 - Father 3 - Sister 5 - Aunts 7 - Grandmother
 2 - Mother 4 - Brother 6 - Uncles 8 - Grandfather

4.3. Has any member of your biological family ever been told by a doctor that they have/had chronic sinusitis (chronic sinus problems)?

1 - Yes 2 - No 3 - Don't know

4.4. Has any member of your biological family ever been treated for eczema (skin rashes)?

1 - Yes 2 - No 3 - Don't know

4.5. Has any member of your biological family ever been treated for hives?

1 - Yes 2 - No 3 - Don't know

PERSONAL MEDICAL HISTORY

These questions are mostly about your chest. Please answer "Yes" or "No" if possible. If you are in doubt about whether your answer is "Yes" or "No," ask the interviewer.

Cough

5A. Do you usually have a cough? Count a cough with first smoke or on first going out-of-doors. Exclude clearing of throat. Don't include coughs related to "colds" or sinus problems.

1 - Yes 2 - No

If "No," skip to Question 5C.

5B. Do you usually cough as much as four to six times a day, four or more days out of the week?

1 - Yes 2 - No

5C. Do you usually cough on waking up or first thing in the morning?

1 - Yes 2 - No

5D. Do you usually cough during the rest of the day or night?

1 - Yes 2 - No

If "Yes" to any of the above questions (5A, 5B, 5C, or 5D), answer the questions in the box below. If your answer is "No" to all of the above questions, skip to Question 6A.

5E. Do you usually cough like this on most days for six consecutive months or more during the year?

1 - Yes 2 - No

5F. For how many years have you had this cough?

Number of years ____

PERSONAL MEDICAL HISTORY (Continued)

Phlegm

6A. Do you usually bring up phlegm from your chest when you cough? Count phlegm with the first smoke or on first going out of doors. Count swallowed phlegm. Don't include phlegm from the nose when you have a sinus infection or cold.

1 - Yes 2 - No

If your answer is "No," skip to Question 6C.

6B. Do you usually bring up phlegm like this as much as twice a day, four or more days out of the week?

1 - Yes 2 - No

6C. Do you usually bring up phlegm at all on waking up, or first thing in the morning?

1 - Yes 2 - No

6D. Do you usually bring up phlegm at all during the rest of the day or night?

1 - Yes 2 - No

If you answered "Yes" to any of the above questions (6A, 6B, 6C, or 6D), answer the questions in the box below. If your answer is "No" to all of the above questions, skip to Question 7A.

6E. Do you bring up phlegm like this on most days for three consecutive months or more during the year?

1 - Yes 2 - No

6F. For how many years have you had trouble with phlegm?

Number of years ___

PERSONAL MEDICAL HISTORY (Continued)

Episodes of Cough and Phlegm

7A. Have you had periods or episodes of persistent cough lasting for three weeks or more each year?

1 - Yes 2 - No

If you answered "No" to all the questions concerning cough or phlegm, please skip to Question 8A.

If you answered "Yes" to Question 7A, answer the questions in the box below.

7B. For how many years have you had at least one such episode per year?

Number of years ____

8A. Have you had periods or episodes of persistent phlegm lasting for three weeks or more each year?

1 - Yes 2 - No

If you answered "No" to all the questions concerning phlegm, please skip to Question 9A.

If you answered "Yes" to Question 8A, answer the questions in the box below.

8B. For how many years have you had at least one such episode per year?

Number of years ____

PERSONAL MEDICAL HISTORY (Continued)

Wheezing

9A. Does your chest ever sound wheezy or whistling:

- | | | | |
|------------------------------------|---------|-------------|--------|
| 1. When you have a cold? | 1 - Yes | No. years__ | 2 - No |
| 2. Occasionally, apart from colds? | 1 - Yes | No. years__ | 2 - No |
| 3. Most days or nights? | 1 - Yes | No. years__ | 2 - No |

If you answered "Yes" to any of the above questions, please indicate the number of years this has been present in the column above.

If you answered "No," skip to Question 10A.

10A. Have you ever had an attack of wheezing that made you feel short of breath?

- 1 - Yes 2 - No

If you answered "Yes" please answer the questions in the box below.

If your answer was "No" please skip to Question 11.

10B. How old were you when you had your first such attack?

Age in years__

10C. Have you had two or more such episodes?

- 1 - Yes 2 - No

10D. Have you ever required medicine for treatment for the(se) attack(s)?

- 1 - Yes 2 - No

PERSONAL MEDICAL HISTORY (Continued)

Breathlessness

11. Do you have difficulty walking caused by some condition other than heart or lung disease?

1 - Yes 2 - No

If you answered "Yes" to Question 11, please briefly describe the problem:

11A. Are you troubled by shortness of breath when hurrying on level surfaces or walking up a slight hill?

1 - Yes 2 - No

If you answered "Yes" to Question 11A, please answer the questions in the box below.

If you answered "No" to Question 11A, please skip to Question 12.

11B. Do you have to walk slower than people of your age on level surfaces because of shortness of breath?

1 - Yes 2 - No

If Yes, at what age did this begin? Age in years _____

11C. Do you ever have to stop for breath when walking at your own pace on a level surface?

1 - Yes 2 - No

If Yes, at what age did this begin? Age in years _____

11D. Do you ever have to stop for breath after walking about 100 yards (the length of a football field) or after a few minutes of walking?

1 - Yes 2 - No

If Yes, at what age did this begin? Age in years _____

11E. Are you too breathless to leave the house or breathless when dressing or undressing?

1 - Yes 2 - No

If Yes, at what age did this begin? Age in years _____

PERSONAL MEDICAL HISTORY (Continued)

Chest Colds and Chest Illnesses

12. If you get a cold, does it usually go to your chest? (Usually means more than one half of the time.)

1 - Yes 2 - No

13A. During the past three years, have you had any kind of chest illnesses or chest conditions that have kept you off work, indoors at home, or in bed?

1 - Yes 2 - No

If you answered "Yes" to Question 13A, please answer the questions in the box below. If you answered "No," please skip to Question 14.

13B. Did you produce phlegm with any of these chest illnesses?

1 - Yes 2 - No

If you answered "Yes" to Question 13B, please answer Question 13C.

13C. In the last three years, how many such illnesses, with (increased) phlegm, did you have which lasted a week or more?

Number of illnesses ____

Past Illnesses (Please ask the interviewer if you have any questions as to how you should answer these questions concerning past medical conditions.)

14. Did you have any lung problems before the age of 16?

1 - Yes 2 - No

If you answered "Yes," please specify the lung problem.

PERSONAL MEDICAL HISTORY (Continued)

15A. Attacks of bronchitis?

1 - Yes 2 - No

If you answered "Yes" to Question 15A, please answer the questions in the box below. If you answered "No," please skip to Question 16A.

<p>15B. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>15C. At what age was your first attack?</p> <p>Age in years? ____</p>

16A. Pneumonia? (Include bronchopneumonia.)

1 - Yes 2 - No

If you answered "Yes" to Question 16A, please answer the questions in the box below. If you answered "No," please skip to Question 17A.

<p>16B. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>16C. At what age did you first have it?</p> <p>Age in years ____</p>
--

PERSONAL MEDICAL HISTORY (Continued)

17A. Pulmonary tuberculosis?

1 - Yes 2 - No

If you answered "Yes" to Question 17A, please answer the questions in the box below. If you answered "No," please skip to Question 18A.

<p>17B. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>17C. At what age did it start?</p> <p>Age in years ____</p>

18A. Have you ever had chronic bronchitis?

1 - Yes 2 - No

If you answered "Yes," to Question 18A, please answer the questions in the box below. If you answered "No," please skip to Question 19A.

<p>18B. Do you still have it?</p> <p>1 - Yes 2 - No</p> <p>18C. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>18D. At what age did it start?</p> <p>Age in years ____</p>

PERSONAL MEDICAL HISTORY (Continued)

19A. Have you ever had emphysema?

1 - Yes 2 - No

If you answered "Yes," to Question 19A, please answer the questions in the box below. If you answered "No," please skip to Question 20A.

<p>19B. Do you still have it?</p> <p>1 - Yes 2 - No</p> <p>19C. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>19D. At what age did it start?</p> <p>Age in years ____</p>

PERSONAL MEDICAL HISTORY (Continued)

20A. Have you ever had asthma?

1 - Yes 2 - No

If you answered "Yes" to Question 20A, please answer the questions in the box below. If you answered "No," please skip to Question 21A.

<p>20B. Do you still have it?</p> <p>1 - Yes 2 - No</p> <p>20C. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>20D. At what age did it start?</p> <p>Age in years ____</p> <p>20E. If you no longer have it, at what age did it stop?</p> <p>Age stopped ____</p> <p>20F. Do you currently require medicine or treatment for asthma?</p> <p>1 - Yes 2 - No</p>
--

PERSONAL MEDICAL HISTORY (Continued)

21A. Have you ever had sarcoidosis?

1 - Yes 2 - No

If you answered "Yes" to Question 21A, please answer the questions in the box below. If you answered "No," please skip to Question 22.

<p>21B. Do you still have it?</p> <p>1 - Yes 2 - No</p> <p>21C. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>21D. At what age did it start?</p> <p>Age in years ____</p> <p>21E. If you no longer have it, at what age did it stop?</p> <p>Age stopped ____</p> <p>21F. Do you currently require medicine or treatment for sarcoidosis?</p> <p>1 - Yes 2 - No</p>

PERSONAL MEDICAL HISTORY (Continued)

22. Have you ever had:

A. Any other chest illness? 1- Yes 2 - No

If "Yes," please specify:

B. Any chest operations? 1 - Yes 2 - No

If "Yes," please specify:

C. Any chest injuries? 1 - Yes 2 - No

If "Yes," please specify:

23A. Hay fever?

1 - Yes 2 - No

If you answered "Yes" to Question 23A, please answer the questions in the box below. If you answered "No," please skip to Question 24A.

<p>23B. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>23C. At what age did it start?</p> <p>Age in years ____</p>

PERSONAL MEDICAL HISTORY (Continued)

24A. Sinus trouble?

1 - Yes 2 - No

If you answered "Yes" to Question 24A, please answer the questions in the box below. If you answered "No," please skip to Question 25A.

<p>24B. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>24C. At what age did it start?</p> <p>Age in years ____</p>

25A. Allergies to bees, wasps, or other insects?

1 - Yes 2 - No

If you answered "Yes" to Question 25A, please answer the questions in the box below. If you answered "No," please skip to Question 26A.

<p>25B. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>25C. At what age did it start?</p> <p>Age in years ____</p>

PERSONAL MEDICAL HISTORY (Continued)

26A. Allergies to animals?

1 - Yes 2 - No

If you answered "Yes," to Question 26A, please answer the questions in the box below. If you answered "No," please skip to Question 27A.

<p>26B. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>26C. At what age did it start?</p> <p>Age in years ____</p>

27A. Allergies to pollens, grasses, or trees?

1 - Yes 2 - No

If you answered "Yes" to Question 27A, please answer the questions in the box below. If you answered "No," please skip to Question 28A.

<p>27B. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>27C. At what age did it start?</p> <p>Age in years ____</p>

PERSONAL MEDICAL HISTORY (Continued)

28A. Allergies to medications?

1 - Yes 2 - No

If you answered "Yes" to Question 28A, please answer the questions in the box below. If you answered "No," please skip to Question 29A.

<p>28B. Was it confirmed by a doctor?</p> <p>1 - Yes 2 - No</p> <p>28C. At what age did it start?</p> <p>Age in years ____</p> <p>28D. Please specify which medications:</p> <table><tr><td>1. Penicillin</td><td>1 - Yes</td><td>2 - No</td></tr><tr><td>2. Aspirin</td><td>1 - Yes</td><td>2 - No</td></tr><tr><td>3. Contrast media for x-rays</td><td>1 - Yes</td><td>2 - No</td></tr><tr><td>4. Other (please specify)</td><td>1 - Yes</td><td>2 - No</td></tr></table> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	1. Penicillin	1 - Yes	2 - No	2. Aspirin	1 - Yes	2 - No	3. Contrast media for x-rays	1 - Yes	2 - No	4. Other (please specify)	1 - Yes	2 - No
1. Penicillin	1 - Yes	2 - No										
2. Aspirin	1 - Yes	2 - No										
3. Contrast media for x-rays	1 - Yes	2 - No										
4. Other (please specify)	1 - Yes	2 - No										

29A.

Has your doctor ever done skin tests to determine whether you have allergies?

1 - Yes 2 - No

If you answered "Yes" to Question 29A, please answer the question in the box below. If you answered "No," please skip to Question 30A.

<p>29B. Were any of the skin tests positive for allergy?</p> <p>1 - Yes 2 - No</p>
--

PERSONAL MEDICAL HISTORY (Continued)

30A. Has your doctor ever given you a series of allergy shots?

1 - Yes 2 - No

If you answered "Yes" to Question 30A, please answer the questions in the box below. If you answered "No," please skip to Question 31A.

<p>30B. Do you still receive these shots?</p> <p>1 - Yes 2 - No</p> <p>30C. At what age did you start the shots?</p> <p>Age in years ____</p>
--

31A. Has a doctor ever told you that you had heart trouble?

1 - Yes 2 - No

If you answered "Yes" to Question 31A, please answer the question in the box below. If you answered "No," please skip to Question 32A.

<p>31B. Have you ever had treatment for heart trouble in the past ten years?</p> <p>1 - Yes 2 - No</p>
--

32A. Has a doctor ever told you that you had high blood pressure?

1 - Yes 2 - No

If you answered "Yes" to Question 32A, please answer the question in the box below. If you answered "No," please skip to Question 33A.

<p>32B. Have you had any treatment for high blood pressure (hypertension) in the past ten years?</p> <p>1 - Yes 2 - No</p>
--

PERSONAL MEDICAL HISTORY (Continued)

33A. Has a doctor ever told you that you have (or had) any other disease or medical condition that you think we should know about? (This question is not limited to respiratory or lung conditions.)

1 - Yes 2 - No

If you answered "Yes" to Question 33A, please provide the following information in the box below. If you answered "No," please skip to Question 34A.

<u>Medical Condition</u>	<u>Year of Diagnosis</u>	<u>Still Under Medical Treatment for This Condition?</u>
_____	19__	1 - Yes 2 - No
_____	19__	1 - Yes 2 - No
_____	19__	1 - Yes 2 - No
_____	19__	1 - Yes 2 - No
_____	19__	1 - Yes 2 - No
_____	19__	1 - Yes 2 - No

34. A. Have you ever had a skin rash related to work?

1 - Yes 2 - No

If you answered "Yes" to Question 34A, please answer the questions in the box below. If you answered "No," please skip to Question 35A.

34B. Was the rash biopsied?

1 - Yes 2 - No

**34C. What did the doctor tell you about the rash?
Please describe briefly.**

PERSONAL MEDICAL HISTORY (Continued)

35A. Have you ever had a cut that took a long time to heal (over one month)?

1 - Yes 2 - No

If you answered "Yes" to Question 35A, please answer the questions in the box below. If you answered "No," please skip to Question 36.

<p>35B. Was this seen by a doctor?</p> <p>1 - Yes 2 - No</p> <p>35C. Was a sample of the tissue sent to a laboratory for examination?</p> <p>1 - Yes 2 - No 3 - Don't know</p> <p>35D. At what age did this occur?</p> <p>Age in years _____</p>
--

36. Have you had any of the following persistent symptoms over the last six months?

- | | | |
|--|---------|--------|
| A. Fevers | 1 - Yes | 2 - No |
| B. Unintentional weight loss of ten or more pounds (when you were not dieting) | 1 - Yes | 2 - No |
| C. Loss of usual energy or abnormal fatigue | 1 - Yes | 2 - No |
| D. Loss of usual appetite | 1 - Yes | 2 - No |
| E. Joint pain | 1 - Yes | 2 - No |

37. Within the last month, have you taken any of the following medications?

- A. Steroids by mouth or injection or inhaled such as Prednisone, hydrocortisone, or Medrol?
- 1 - Yes 2 - No

38. Have you had any respiratory infections, such as a cold or the flu in the last month?

1 - Yes 2 - No

MEDICAL HISTORY (Continued)

39. Have you ever lived in an area that you considered to be air-polluted?

1 - Yes 2 - No

If you answered "Yes" to Question 39, please provide the following information in the box below. An example is provided.

<u>Location</u>	<u>No. of Years in Residence</u>	<u>Pollutant</u>	<u>Source of Pollution</u>	<u>Residence How Close to Source (miles)</u>
0. Tacoma, WA	9 years	Arsenic	Arsenic smelter	2 miles
1.				
2.				
3.				
4.				

You have completed the Questionnaire. If there are any questions that you are unsure how to answer, please consult the Surveillance Program Coordinator. Thank you for your participation.