

**SENSITIZER MEDICAL SURVEILLANCE  
BASELINE QUESTIONNAIRE**

\_\_\_\_\_  
*Date of examination*

\_\_\_\_\_  
*Location*

\_\_\_\_\_  
*Name (Print)*

\_\_\_\_\_  
*Social Security Number*

\_\_\_\_\_  
*Employer (Print)*

\_\_\_\_\_  
*Unit Assignment*

*Please check the single best answer to each question*

**Have you ever been evaluated by a physician for any of the following medical problems?**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1.1 Skin trouble or rashes                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.2 Recurrent Eczema or Dermatitis                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.3 Any other skin problem that you've been told about | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.4 Allergy to workplace chemicals or substances       | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.5 Reactions to drugs or chemicals                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 1.6 Any other allergy that you've been told about      | <input type="checkbox"/> | <input type="checkbox"/> |

**Smoking History**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 2.1 Have you ever smoked ?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.2 Do you currently smoke tobacco,<br>or have you smoked tobacco in the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.3 How many cigarettes per day? _____ cigarettes                                    |                          |                          |
| 2.4 How many years (total) have you smoked cigarettes? _____ years                   |                          |                          |
| 2.5 If you have quit, how many years ago? _____ years                                |                          |                          |
| 2.6 Have you ever had a "Smoker's Cough"?  | <input type="checkbox"/> | <input type="checkbox"/> |

**Have you ever had any of the following health problems diagnosed?**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 3.1 Asbestosis  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.2 Acute bronchitis                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.3 Asthma  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.4 Allergic reactions that interfere with your breathing | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.5 Byssinosis (breathing problems from cotton dust)      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.6 Chest discomfort with exercise/cold weather           | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.7 Chronic bronchitis/ Emphysema                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.8 Pneumonia   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.9 Tuberculosis  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.10 Silicosis (lung disease due to sand exposure)        | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.11 Any chest injuries or surgeries                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.12 Any other lung problem that you've been told about   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.13 Any heart problem that you've been told about        | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.14 Gastric reflux/ Hiatal hernia                        | <input type="checkbox"/> | <input type="checkbox"/> |

**During the past four weeks:**

	Yes	No
4.1 Has your chest felt tight or your breathing become difficult?	<input type="checkbox"/>	<input type="checkbox"/>
4.2 Has your chest sounded wheezing or whistling?	<input type="checkbox"/>	<input type="checkbox"/>
4.3 Have you had a persistent or regular cough?	<input type="checkbox"/>	<input type="checkbox"/>
4.4 Have you developed a new skin rash?	<input type="checkbox"/>	<input type="checkbox"/>
4.5 Recurrent soreness or watering of your eyes?	<input type="checkbox"/>	<input type="checkbox"/>
4.6 Recurrent blocked or running nose?	<input type="checkbox"/>	<input type="checkbox"/>
4.7 Have you consulted a doctor about chest problems?	<input type="checkbox"/>	<input type="checkbox"/>
4.8 Are you currently taking any medicines or inhalers for chest problems?	<input type="checkbox"/>	<input type="checkbox"/>

**If yes to any of the above, please answer the following questions:**

5.1 If you run, or climb stairs fast do you

5.11	cough?	<input type="checkbox"/>	<input type="checkbox"/>
5.12	wheeze?	<input type="checkbox"/>	<input type="checkbox"/>
5.13	get tight in the chest?	<input type="checkbox"/>	<input type="checkbox"/>

5.2 Is your sleep broken by

5.21	wheeze?	<input type="checkbox"/>	<input type="checkbox"/>
5.22	difficulty with breathing?	<input type="checkbox"/>	<input type="checkbox"/>

5.3 Do you wake up in the morning (or from sleep, if a shift worker) with

5.31	wheeze?	<input type="checkbox"/>	<input type="checkbox"/>
5.32	difficulty with breathing?	<input type="checkbox"/>	<input type="checkbox"/>

5.4 Do you wheeze

5.41	if you are in a smoky room?	<input type="checkbox"/>	<input type="checkbox"/>
5.42	if you are in a very dusty place?	<input type="checkbox"/>	<input type="checkbox"/>

5.5 What happens to your symptoms

5.51 On weekends?  better  same  worse

5.52 On holidays of 4 days or more?  better  same  worse

5.53 With exposure to a particular substance or process?

Please describe on the back of the page.

I declare to the best of my knowledge that the answers to the questions above are complete and accurate.

\_\_\_\_\_  
*Employee's Signature*

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

**Health Professional Reviewer**

- No further action required
- Refer to occupational health physician for additional evaluation

Name of Physician: \_\_\_\_\_

Date of appointment: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
*Health Professional Reviewer's Signature*

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

\_\_\_\_\_  
*Health Professional Reviewer's Name (Printed)*