



GREAT LAKES
PHYSICIAN SERVICES

C. Have you ever been exposed to gas or chemical fumes in your work? 1. Yes ___ 2. No ___
Specify job/industry _____ Total Years Worked ___
Was exposure : 1. Mild ___ 2. Moderate ___ 3. Severe ___

D. What has been your usual occupation/job?
The job you have worked at the longest?
1. Occupation _____
2. Number of years employed in this occupation _____
3. Position/job title _____
4. Business, field or industry _____

(Please mark below the years in which you have worked in the following industries, e.g. 1980-1989)

Have you ever worked:	YES	NO
E. In a mine?	_____	_____
F. In a quarry?	_____	_____
G. In a foundry?	_____	_____
H. In a pottery?	_____	_____
I. In a cotton, flax or hemp mill?	_____	_____
J. With asbestos?	_____	_____

18. PAST MEDICAL HISTORY

	YES	NO
A. Do you consider yourself to be in good health?	_____	_____
If "NO" state reason _____		
B. Have you any defect of vision?	_____	_____
If "YES" state nature of defect _____		
C. Have you any hearing defect?	_____	_____
If "YES" state nature of defect _____		

D. Are you suffering from or have you ever suffered from:

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- | | YES | NO |
|---|-------|-------|
| a. Epilepsy (or fits, seizures, convulsions)? | _____ | _____ |
| b. Rheumatic fever? | _____ | _____ |
| c. Kidney disease? | _____ | _____ |
| d. Bladder disease? | _____ | _____ |
| e. Diabetes? | _____ | _____ |
| f. Jaundice? | _____ | _____ |

19. If you get a cold, does it go to your chest more than 1/2 the time?
1. Yes ___ 2. No ___ 3. Don't get colds ___

20A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?

1. Yes ___ 2. No ___

IF YES TO 20A:

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

1. Yes ___ 2. No ___

C. In the last 3 years, how many such illnesses with increased phlegm did you have which lasted a week or more?

Number of illnesses ___

21. Did you have any lung trouble before the age of 16?

1. Yes ___ 2. No ___

22. Have you ever had any of the following?

1A. Attacks of bronchitis?

1. Yes ___ 2. No ___

IF YES TO 1A:

B. Was it confirmed by a doctor?

1. Yes ___ 2. No ___

C. At what age was your first attack?

Age in Years ___

22A. Pneumonia (include bronchopneumonia)?

1. Yes ___ 2. No ___

IF YES TO 22A:

B. Was it confirmed by a doctor?

1. Yes ___ 2. No ___

C. At what age did you first have it?

Age in Years ___

D. Hay Fever?

1. Yes ___ 2. No ___

At what age did it start?

Age in Years ___

23. Have you ever had chronic bronchitis?

1. Yes ___ 2. No ___

IF YES TO 23:

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- B. Do you still have it? 1. Yes ___ 2. No ___
- C. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
- D. At what age did it start? Age in Years ___
- 24A. Have you ever had emphysema? 1. Yes ___ 2. No ___
IF YES TO 24A:
B. Do you still have it? 1. Yes ___ 2. No ___
- C. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
- D. At what age did it start? Age in Years ___
- 25A. Have you ever had asthma? 1. Yes ___ 2. No ___
IF YES TO 25A:
B. Do you still have it? 1. Yes ___ 2. No ___
- C. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
- D. At what age did it start? Age in Years ___
- E. If you no longer have it, at what age did it stop?
Age stopped ___
26. 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 _____
- 27A. Has a doctor ever told you that you have heart trouble?
1. Yes ___ 2. No ___
IF YES TO 27A:
B. Have you ever had treatment for heart trouble in the past 10 years?
1. Yes ___ 2. No ___
- 28A. Has a doctor told you that you have/had high blood pressure?
1. Yes ___ 2. No ___
IF YES TO 28A:
B. Have you had any treatment for high blood pressure in the past 10 years?
1. Yes ___ 2. No ___
29. When did you last have a chest X-ray?
(Year) _____



30. If known, please list where you last had a chest X-ray?

What was the result/outcome? _____

FAMILY HISTORY

31. Were either of your birth parents ever told by a doctor that they had a chronic lung condition such as:

	FATHER			MOTHER		
	1. Yes	2. No	3. Don't know	1. Yes	2. No	3. Don't know

A. Chronic Bronchitis?

B. Emphysema?

C. Asthma?

D. Lung cancer?

E. Other chest conditions?

F. Is parent currently alive?

G. Please Specify

_____ Age if Living	_____ Age if Living
_____ Age at Death	_____ Age at Death
_____ Don't Know	_____ Don't Know

H. Please specify cause of death

COUGH

32A. Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.)

(If no, skip to question 32C)

1. Yes ___ 2. No ___

B. Do you usually cough as much as 4-6 times a day 4 or more days out of the week?

1. Yes ___ 2. No ___

C. Do you usually cough at all on getting up or first thing in the morning?

1. Yes ___ 2. No ___

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

1. Yes ___ 2. No ___

IF YES TO ANY OF ABOVE (32A, B, C, OR D) ANSWER THE FOLLOWING.

IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO 33.



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E. Do you usually cough like this on most days for 3 consecutive months or more during the year?

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

F. For how many years have you had the cough?

Number of years ___
Does not apply ___

33A. Do you usually bring up phlegm from your chest?

(Phlegm with the first smoke, on first going out of doors and swallowed phlegm. Exclude phlegm from the nose. (If no, skip to 33C)

1. Yes ___ 2. No ___

B. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week?

1. Yes ___ 2. No ___

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

1. Yes ___ 2. No ___

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

1. Yes ___ 2. No ___

IF YES TO ANY OF THE ABOVE (33A, B, C, OR D ANSWER THE FOLLOWING:

IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO 34A

E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?

1. Yes ___ 2. No ___

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

Number of years ___
Does not apply ___

EPISODES OF COUGH AND PHLEGM

34A. Have you had periods or episodes of increased* cough and phlegm lasting for 3 weeks or more each year?

*(For persons who usually have cough and/or phlegm)

1. Yes ___ 2. No ___

IF YES TO 34A

B. For how long have you had at least 1 such episode per year?

Number of years ___
Does not apply ___

WHEEZING

35A. Does your chest ever sound wheezy or whistling

1. When you have a cold?

1. Yes ___ 2. No ___



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2. Occasionally apart from colds? 1. Yes ___ 2. No ___

3. Most days or nights? 1. Yes ___ 2. No ___

IF YES TO 1, 2, or 3 in 35A

B. For how many years has this been present? Number of years ___

36A. Have you ever had an attack of wheezing that has made you feel short of breath?

1. Yes ___ 2. No ___

IF YES TO 36A

B. How old were you when you had your first such attack? Age in years ___

C. Have you had 2 or more such episodes? 1. Yes ___ 2. No ___

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

1. Yes ___ 2. No ___

BREATHLESSNESS

37. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 39A.

Nature of condition(s) _____

38A. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?

1. Yes ___ 2. No ___

IF YES TO 38A

B. Do you have to walk slower than people your age on level ground because of breathlessness? 1. Yes ___ 2. No ___

C. Do you ever have to stop for breath when walking at your own pace on the level? 1. Yes ___ 2. No ___

D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level? 1. Yes ___ 2. No ___

E. Are you too breathless to leave the house or breathless on dressing

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or climbing one flight of stairs?

1. Yes ___ 2. No ___

TOBACCO SMOKING

39A. Have you ever smoked cigarettes?
(No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime
or less than 1 cigarette a day for 1 year.)

1. Yes ___ 2. No ___

IF YES TO 39A

B. Do you now smoke cigarettes (as of one month ago)

1. Yes ___ 2. No ___

C. How old were you when you first started regular cigarette smoking?
Age in years ___

D. If you have stopped smoking cigarettes completely, how old were you
when you stopped?

Age stopped ___
Check if still smoking ___

E. How many cigarettes do you smoke per day now?

Cigarettes per day ___

F. On the average of the entire time you smoked, how many cigarettes
did you smoke per day?

Cigarettes per day ___

G. Do or did you inhale the cigarette smoke?

- 1. Does not apply ___
- 2. Not at all ___
- 3. Slightly ___
- 4. Moderately ___
- 5. Deeply ___

40A. Have you ever smoked a pipe regularly?
(Yes means more than 12 oz. of tobacco in a lifetime.)

1. Yes ___ 2. No ___

IF YES TO 40A:

FOR PERSONS WHO HAVE EVER SMOKED A PIPE

B. 1. How old were you when you started to smoke a pipe regularly?
Age ___

C. If you have stopped smoking a pipe completely, how old were you
when you stopped?

Age stopped ___
Check if still smoking pipe ___

D. On the average over the entire time you smoked a pipe, how much pipe
tobacco did you smoke per week?



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(a standard pouch of tobacco contains 1 1/2 oz.) _____ oz. per week

E. How much pipe tobacco are you smoking now?
oz. per week _____
Not currently smoking a pipe _____

F. Do you or did you inhale the pipe smoke?
1. Never smoked _____
2. Not at all _____
3. Slightly _____
4. Moderately _____
5. Deeply _____

41A. Have you ever smoked cigars regularly?
1. Yes _____ 2. No _____
(Yes means more than 1 cigar a week for a year)

IF YES TO 41A
FOR PERSONS WHO HAVE EVER SMOKED A CIGARS

B. 1. How old were you when you started smoking cigars regularly? Age _____
2. If you have stopped smoking cigars completely, how old were you when you stopped. Age stopped _____
Check if still smoking cigars _____

C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week? Cigars per week _____

D. How many cigars are you smoking per week now? Cigars per week _____
Check if not smoking cigars currently _____

E. Do or did you inhale the cigar smoke?
1. Never smoked _____
2. Not at all _____
3. Slightly _____
4. Moderately _____
5. Deeply _____

****Medication List****

Name _____ ***Dose*** _____ ***Frequency*** _____



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Surgical Procedures

DATE (month/year)

Procedure

DATE (month/year)	Procedure

Print Name: _____

Signature: _____