BRONSON

Affix Patient Label

1. Name: _____ **2**. Social Security #:_____

3. Present Occupation/Job Title: _____ **4**. Company: _____

5. Address: _____(Zip Code) _____

6. Telephone Number: _____

7. Date: _____ **8**. Date of Birth: _____

OCCUPATIONAL HISTORY

9. 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 9A:

B. In the past year, did you work in a dusty job? ☐ Yes ☐ No ☐ Does Not Apply

Was dust exposure: ☐ Mild ☐ Moderate ☐ Severe

C. In the past year, were you exposed to gas or chemical fumes in your work? ☐ Yes ☐ No

Was exposure: ☐ Mild ☐ Moderate ☐ Severe

D. In the past year, what was your: Job occupation _____ Position/job title: _____

RECENT MEDICAL HISTORY

10. Do you consider yourself to be in good health? ☐ Yes ☐ No

If "NO", state reason _____

11. In the past year, have you developed:

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

CHEST COLDS & CHEST ILLNESS

12. If you get a cold, does it usually go to your chest? (usually means more than ½ the time)

☐ Yes ☐ No ☐ Don't get colds

13. A. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? ☐ Yes ☐ No ☐ Does not Apply

If "YES" to 13:

B. Did you produce phlegm with any of these chest illnesses? ☐ Yes ☐ No ☐ Does Not Apply

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

☐ No such illnesses ☐ Number of illnesses _____

BRONSON

Affix Patient Label

RESPIRATORY SYSTEM

15. In the past year have you had:	Yes	No	Further Comment on Positive Answers
Asthma	☐	☐	_____
Bronchitis	☐	☐	_____
Hay Fever	☐	☐	_____
Other Allergies	☐	☐	_____
Pneumonia	☐	☐	_____
Tuberculosis	☐	☐	_____
Chest Surgery	☐	☐	_____
Other Lung Problems	☐	☐	_____
Heart Disease	☐	☐	_____
16. Do you have:	Yes	No	Further Comment on Positive Answers
Frequent colds	☐	☐	_____
Chronic cough	☐	☐	_____
Shortness of breath when walking or climbing one flight of stairs	☐	☐	_____
17. Do you:			
Wheeze	☐	☐	_____
Cough up phlegm	☐	☐	_____
Smoke cigarettes	☐	☐	Packs per day _____ How many years _____

Signature _____ Date _____

Reviewed by:_____Date:_____Time:_____