Building Trades National Medical Screening Program
1-800-866-9663

Medical History Questionnaire

Name: _____

Address: _____

City: _____State: _____ Zip _____

Phone Number (include Area Code): _____

Email Address: _____

Social Security # (last 4 numbers) XXX-XX- _____ Date of Birth_____

Family Medical History

Family Physician Name: _____

Address: _____

City: _____State _____ Zip _____

Family Physician Phone (include Area Code) _____

Race (Check One Only)

White_____ Black_____ Hispanic_____ Asian/Pacific Islander_____

Aleutian Alaskan/Native American_____ Other_____ If other is checked, state here: _____

Sex

Male____ Female_____ Height _____ Weight _____

If female, are you or could you be pregnant? Yes_____ No_____

Note: This program is conducted in compliance with all laws and regulations regarding civil rights. Your race, age, and sex are required to determine the results of various laboratory tests that vary from normal ranges and for no other purpose and will be kept strictly confidential on your medical record.

I. Personal History

A. **Please indicate if you have ever been told by a doctor that you have any of the following cancers:**

	Yes	No	Don't know
Leukemia			
Acute myelogenous leukemia			
Chronic myelogenous leukemia			
Acute lymphocytic leukemia			
Chronic lymphocytic leukemia			
Multiple Myeloma			
Hodgkin's Disease			
Non-Hodgkin's Lymphoma			
Bone cancer			
Lung cancer			
Thyroid cancer			
Kidney cancer			
Cancer of the ureters			
Bladder cancer			
Brain cancer			
Breast cancer			
Esophagus cancer			
Stomach cancer			
Colon or other Intestinal cancer			
Pancreatic cancer			
Liver cancer			
Cancer of Gall Bladder or Bile Ducts			
Cancer of the mouth, head or neck			
Pharyngeal cancer			
Salivary gland or parotid gland cancer			
Other type, list if possible:			
Ovarian cancer			
Uterine cancer			
Cervical cancer			
Testicular cancer			
Prostate cancer			
Skin cancer (basal cell or squamous)			
Skin cancer (Melanoma)			
Other cancer, list name:			

B. Please indicate if you ever had any of the following medical conditions:

Condition	Yes	No	Don't know
Diabetes			
Beryllium Sensitivity			
Chronic Beryllium Disease			
Silicosis			
Asbestosis			
Another lung problem (what is it?)			
High Blood Pressure			
Kidney Disease			
Thyroid disease			
Muscle Disease			
Mercury, lead or other metal poisoning			
Solvent poisoning			
Other**			

**If "Other" is checked, please name the condition in the space allowed. Use the lines below if you need more room.

_____
_____
_____

1. Is your mother currently living? ___Yes ___No ___Don't Know
   a. Age if living: _____
   b. Age at death: _____ c. Cause of death _____

2. Is your father currently living? ___Yes ___No ___Don't Know
   a. Age if living: _____
   b. Age at death: _____ c. Cause of death _____

Have you had your flu vaccine? ___Yes ___No If yes, when did you have it? Year _____

Have you received the COVID-19 vaccine? __Yes __No __Doesn't Plan to __Declined to Answer

If yes, have you received a booster? ___Yes ___No

If yes, how many? _____

Have you ever been diagnosed with COVID-19? ___Yes ___No

If yes, date of diagnosis: Month: _____ Year: _____

Medication History

Please list your present medications:

_____

_____

_____

C. Have you ever had surgery for any of the following areas?

Area	Yes	No	If Yes, Date
Abdomen			
Back			
Bones or joints			
Chest			
Eye			
Head, neck, thyroid			
Heart			
Kidney, bladder, urethra			
Liver			
Lung, breast			
Rectum			
Other:			

If you have had surgery for any of the above conditions, please describe in more detail (diagnosis, reason for surgery)

_____

_____

II. Medical History

A. Cardiovascular

	Yes	No
Congestive Heart Failure		
Heart Attack		
Abnormal stress test		
Blood clots in veins		
Irregular heartbeat		
Chest pain on exertion		
Chest pain at rest		
Swelling in legs		
Heart murmur		
Short of breath when lying down		
Awaking at night short of breath		

B. Respiratory

1. Have you ever had any of the following:

	Yes	No
Attacks of bronchitis?		
Was it confirmed by a doctor?		
a. At what age was your first attack? Age: _____ Don't know: ____		

	Yes	No
Pneumonia (including bronchopneumonia)?		
Was it confirmed by a doctor?		
b. At what age did you first have it? Age: _____ Don't know: ____		

	Yes	No
Hay fever?		
Was it confirmed by a doctor?		
c. At what age did it start? Age: _____ Don't know: ____		

	Yes	No
Chronic bronchitis?		
Do you still have it?		
Was it confirmed by a doctor?		
d. At what age did it start? Age: _____ Don't know: ____		

	Yes	No
Emphysema?		
Do you still have it?		
Was it confirmed by a doctor?		
e. At what age did it start? Age: _____ Don't know: ____		

	Yes	No
Asthma?		
Do you still have it?		
Was it confirmed by a doctor?		

f. At what age did it start? Age: _____ Don't know: ____

g. If you no longer have it, at what age did it stop? Age: _____ Don't know: ____

	Yes	No
Chest injuries?		

If YES, please specify:

	Yes	No
Any other chest illnesses?		

If YES, please specify:

h. When did you last have your chest x-rayed?

i. Where did you last have your chest x-rayed?

j. What was the outcome?

	Yes	No
k. If you get a cold, does it usually (i.e. more than half the time) go to your chest?		
l. During the past three years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?		

Cough

	Yes	No
a. Do you usually have a cough?		
b. If YES: **Do you usually cough as much as two times a day 4 or more days out of the week?**		
Do you usually cough at all on getting up or first thing in the morning?		
Do you usually cough at all during the rest of the day or at night?		
	Yes	**No**
c. If YES to any of the above: d. Do you usually cough like this on most days for 3 consecutive months or more during the year?		

e. If YES: For how many years have you had the cough? _____Years

Phlegm

	Yes	No
a. Do you usually bring up phlegm from your chest? (Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.)		
b. If YES: **Do you usually bring up phlegm as much as twice a day 4 or more days out of the week?**		
Do you usually bring up phlegm at all on getting up or first thing in the morning?		
Do you usually bring up phlegm at all during the rest of the day or at night?		
c. If YES to any of the above:		
d. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?		
Have you had periods or episodes of increased cough and phlegm lasting for 3 weeks or more each year?		
If YES: How long have you had at least one such episode per year? _____ Years		

Does your chest ever sound wheezy or whistling:	Yes	No
• When you have a cold?		
• Occasionally apart from colds?		
• Most days or nights?		
If YES to any of these, how many years has this been present? _____ Years		

	Yes	No
Have you ever had an attack of wheezing that has made you feel short of breath?		
If YES, • How old were you when you had your first such attack? _____ years		
• Have you had 2 or more such episodes?		
• Have you ever required medicine for these episodes?		

Breathlessness

	Yes	No
Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?		
Do you have to walk slower than people of your age because of breathlessness?		
Do you ever have to stop for breath when walking at your own pace on the level?		
Do you ever have to stop for breath after walking 100 yards (or after a few minutes) on the level?		
Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs?		

C. Cigarette Smoking

	Yes	No
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.)		
Do you now smoke cigarettes (as of one month ago)?		

If YES to either of the above questions:

	Age	Don't Know
How old were you when you first started regular cigarette smoking?		
If you have stopped, how old were you when you stopped completely?		
	#	**Don't Know**
How many cigarettes did you or do you smoke per day?		
On average of the entire time you smoked, how many cigarettes did you or do you smoke per day?		
Do you or did you inhale the cigarette smoke? ___Not at all ___Slightly ___Moderately ___Deeply		

If you still smoke:

	Yes	No	Don't Know
a. Would you like to quit?			
b. Have you tried to quit?			
			# of times:
c. If "yes" on b., How many times have you tried to quit? 1= Once 2= 2-6 times 3= 6-12 times 4=>12 times			
	Yes	**No**	**Don't Know**
d. Have you stopped smoking for >1 day during the past 12 months because you are trying to quit smoking?			

If you smoked but have quit:

	Yes	No	Don't know
a. Did you quit because you had a serious medical problem (such as a heart attack)?			

If No or don't know to the above question:

	Yes	No	Don't know
a. Did you quit on your own without any help?			

If No or don't know to the above question:

	Yes	No	Don't know
a. What kind of help did you use to quit? (check all that apply)			
1. Advice from health care professional			
2. Telephone counseling			
3. Group sessions			
4. Medications (patch/gum/Chantix/varenicline/Zyban/Wellbutrin/bupropion)			
5. Electronic cigarettes (e-cigarettes) also known as Vaping?			
6. Other (hypnosis/acupuncture, etc.)			

D. E-Cigarettes or Vaping

	Yes	No
Have you ever used electronic cigarettes (e-cigarettes) also known as Vaping?		
Do you currently use electronic cigarettes (e-cigarettes), Vaping?		

E. Cigar and pipe smoking

	Yes	No
Have you ever smoked a pipe or cigars?		
Do you currently smoke a pipe or cigars		

If YES to either of the above questions:

	Number of years
About how many years did you smoke a pipe or cigars?	

F. Allergies

Are you allergic to any of the following:

	Yes	No
Chemicals		
Drugs		
Dusts		
Pollen or grasses		

If yes, please list specific allergies:

_____

_____

G. Alcohol History

	Yes	No
Never drink		
Social drinker (1-6 drinks per week)		
1 or 2 drinks daily		
3 or more drinks daily		
Recovering alcoholic		

H. Neurology

	Yes	No
Head injury		
Emotional Irritability		
Fainting spells		
Memory loss		
Severe dizziness		
Headaches, frequent or severe		
Sleep disorder		
Speech difficulty		
Tingling in hands or feet		
Tremor		
Psychiatric or Emotional Disorder		
Stroke		
Epilepsy, seizures		

I. Eyes

	Yes	No
Eye injury		
Blurred vision		
Cataracts		
Double vision		
Glaucoma		

J. Ears

	Yes	No
Ear surgery		
Hearing loss		
Punctured eardrum		
Ringing in the ears		
Other ear diseases		

Do you have problems:

	Yes	No	Don't Know
Hearing or understanding normal conversation?			
Hearing in noisy areas?			
Hearing at the movies or church?			
Hearing on the job?			
Do you have ringing in your ears?			
If you have problems, did your hearing change suddenly?			
Do you have vertigo, dizziness, or balance problems?			
Have you ever had a concussion or head injury?			
Is hearing loss hereditary in your family?			
Have you had your hearing evaluated before?			
Have you ever used a hearing aid?			
Have you filed a workers compensation claim for hearing loss?			

K. Nose

	Yes	No
Frequent nosebleeds		
Loss of smell		
Frequent sinusitis		

L. Mouth

	Yes	No
Bleeding or sore gums		
Difficulty swallowing		
Discoloration or white areas in mouth		
Loss of taste		
Persistent hoarseness		
Sores in mouth		

M. *Bones and Joints*

	Yes	No
Bone infection		
Bursitis		
Gout		
Herniated disc		
Lumbar-sacral strain		
Arthritis		
Pains in arms and legs		
Rheumatoid arthritis		
Sciatica		
Stiff muscles and joints		

N. *Stomach/Intestines*

	Yes	No
Bloody stool		
Cirrhosis of liver		
Colitis		
Diverticulitis		
Ulcer		
Enlarged liver		
Abnormal liver tests		
Enlarged spleen		
Gall bladder disease		
Pancreatitis		
Jaundice		
Loss of appetite		
Frequent nausea/vomiting		

O. *Skin*

*Included with your packet is information on UV radiation. Please do your self-skin examination and mark the Body Map provided on page 14 for any skin concerns identified. Bring the map with you to the examination and have the doctor look at the areas you have identified.

	Yes	No
Contact dermatitis		
Eczema		
Hives		
Other skin diseases		

P. ***Blood Systems***

	Yes	No
Anemia		
Blood diseases		
Do you bruise easily?		
Have you ever had a blood transfusion?		
Hemophilia		

Q. ***Please indicate if you participate in the following activities:***

	Yes	No
Gardening		
Stained glass work		
Silk screening		
Paint removal		
Model plane/car building		
Pottery/ceramics		
Melting metal for any purpose		
Volunteer fire fighting		
Woodworking		
Jewelry making		
Mimeographing		
House painting		
Furniture refinishing		
Indoor fire range practice		
Cutting wood with a chainsaw		
Drag or auto racing		
Hunting		
Listening to loud music		
Operating farm machinery		
Operating home power tools		
Operating motorboats		
Operating motorcycles		
Playing in a band		
Private flying		
Scuba diving		
Skeet or target shooting		
Sky diving		

Please indicate any other hobby to which you devote a considerable amount of time.

_____

Please sign here to verify this is your history: _____

Examining Doctor please initial here to verify that you have reviewed this. _____

Refer to the UV Radiation information sheet provided in your medical packet and the attached sheet on how to do self-examination of your skin.

ON THE BODY MAP BELOW, PLEASE MARK LOCATIONS WHERE YOU NOTICE ANY MOLES OR LESIONS YOU WANT THE DOCTOR TO LOOK AT DURING YOUR EXAM. IF YOU HAVE IDENTIFIED AREAS OF CONCERN, BE SURE TO ASK THE DOCTOR TO REVIEW THESE DURING YOUR EXAMINATION