wcb Workers' Compensation Board – Alberta

C013

PULMONARY HISTORY QUESTIONNAIRE

Box 2415
Edmonton AB T5J 2S5
Fax: (780) 427-5863
1-800-661-1993

WCB Claim Number

Personal Health Number

Worker's *(Surname)* *(First Name)* *(Initials)*

Date of Birth *(Year / Month / Day)*

Address *Street* *City/Town*

Province

Postal Code

Telephone Number ( )

Current Age

Height

Weight

Gender ☐ Male ☐ Female

1. OCCUPATIONAL HISTORY

Have you ever worked:

A. In a:

	Yes	No	Job Description
1. mine	☐	☐	
2. quarry	☐	☐	
3. foundry	☐	☐	
4. pottery	☐	☐	
5. cotton, flax or hemp mill	☐	☐	
6. brick plant	☐	☐	
7. glass or ceramics factory	☐	☐	
8. abrasives factory	☐	☐	
9. chemical plants *(specify)* _____	☐	☐	
10. other *(specify)* _____	☐	☐	

B. With:

	Yes	No	Job Description
1. asbestos	☐	☐	
2. a sandblaster	☐	☐	
3. coal	☐	☐	
4. wood dust	☐	☐	
5. uranium	☐	☐	
6. grain dust	☐	☐	
7. other *(specify)* _____	☐	☐	

C. With the following:

	Yes	No	If yes, *(specify)*
1. solvents	☐	☐	
2. acids	☐	☐	
3. plastics	☐	☐	
4. TDI (toluene di-isocynate)	☐	☐	
5. other chemicals, irritants or fumes	☐	☐	

2. ILLNESSES

A. Have you ever been told you have any of the following conditions?

	Yes	No	Physician's name, address and telephone number	Reason	Treatment/Test date(s) *(Year / Month / Day)*
1. Asthma	☐	☐			
2. Emphysema	☐	☐			
3. Chronic bronchitis	☐	☐			
4. Pneumonia	☐	☐			
5. Tuberculosis	☐	☐			
6. Pleurisy	☐	☐			
7. Sinusitis	☐	☐			

Worker's *Surname*	*First Name*	*Initial*	WCB Claim Number

2. ILLNESSES (Continued)

	Yes	No		
8. Pneumothorax				
9. Diabetes				
10. Eczema				
11. Cancer (specify)				
12. Allergies (specify)				
13. Heart (specify)				
14. Other (specify)				

B. Have you ever undergone surgery to your chest, nose, sinuses, or upper abdomen? ☐ Yes ☐ No

If yes, why _____ when _____

3. FAMILY HISTORY

A. Have any family members suffered from any condition(s) listed in 2A (previous page)? If so, indicate below

Relationship	Condition(s)

4. MEDICAL TREATMENT

A. List occasions on which you visited physician(s) for your current respiratory condition. Attach a separate sheet if necessary.

Physician's name, address and telephone number	Reason	Treatment/Test date(s) *(Year / Month / Day)*

B. Are you currently taking any medication? (prescribed or "over the counter") ☐ Yes ☐ No

Name of Medication	Prescribing Doctor

5. LIFESTYLE - Smoking

A. Have you ever smoked cigarettes?

If yes, How many per day? _____

When did you start? _____

Quit? At what age? _____

Have you ever smoked a pipe or cigar on a regular basis? ☐ Yes ☐ No

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6. SYMPTOMS

A. Coughing

Do you cough? ☐ Yes ☐ No If yes, when? _____

B. Sputum

i) How many times do you bring up phlem per day? _____

ii) What colour is it? _____

iii) Is it ever bloody? ☐ Yes ☐ No

iv) ☐ Thick or ☐ Thin

C. Do you have chest pain? ☐ Yes ☐ No

If yes, i) Where on the chest? _____

ii) What does it feel like? _____

iii) What makes it worse? _____

iv) What makes it better? _____

D. Do you have shortness of breath? _____

If yes, what are you doing at the time? _____

E. Wheezing

When you breathe, is it noisy? ☐ Yes ☐ No

If yes, in what situations does it happen? _____

Comments

_____

_____

_____

_____

I, the claimant, declare the above information to be true and correct to the best of my knowledge

Date: Name (please print): Signature: