Workers' Compensation Board
Alberta

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C684

CARDIAC QUESTIONNAIRE

WCB Claim Number

Personal Health Number

Worker's *Surname* *First Name* *Initial*

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

Address *Street* *City/Town* *Province*

Postal Code

Telephone Number ( )

Current Age

Height

Weight

Gender ☐ Male ☐ Female

Employment History

A) Current Job Title _____

Job Duties _____

_____

Would you describe your job as:

- ☐ Heavy physical (over 50 lbs)
- ☐ Moderate physical (up to 50 lbs)
- ☐ Light physical (10 to 40 lbs)
- ☐ Requires mainly thinking and writing
- ☐ Sedentary (Non-physical)
- ☐ Stressful (explain) _____

B) At the time of your cardiac episode, were you performing your normal, regular work duties? ☐ Yes ☐ No If not, explain duties being performed.

_____

_____

C) What were you doing twenty-four hours (1 day) preceding your cardiac episode? (Both at home and at work)

_____

D) Were you exposed to any chemicals or noxious fumes during this 24 hour period? ☐ Yes ☐ No If yes, specify.

_____

Medical Information

Have you ever had any of the following:

	Yes	No	Since when?	Treating Physician/Hospital	Medication Prescribed
1. Palpitations	☐	☐			
2. Ankle edema (swelling)	☐	☐			
3. Angina (chest pain)	☐	☐			
4. Hypertension (high blood pressure)	☐	☐			
5. Myocardial infarction (heart attack)	☐	☐			
6. Rheumatic fever	☐	☐			
7. Cardiac murmur	☐	☐			
8. Fatigue	☐	☐			
9. Traumatic chest injury	☐	☐			
10. Diabetes	☐	☐			
11. Stroke	☐	☐			
12. Heart disease	☐	☐			
13. High cholesterol	☐	☐			

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

Medical Information Continued

	Yes	No	Since when?	Treating Physician/Hospital	Medication Prescribed
14. Emphysema	☐	☐			
15. Any respiratory condition not listed	☐	☐			
16. Other *(specify)*	☐	☐			

Lifestyle

A. Smoking

1. Have you ever smoked? ☐ Yes ☐ No If yes, how many per day _____

	Minimum	From-To (month/year)	Average	From-To (month/year)	Maximum	From-To (month/year)
Cigarettes						
Pipe						
Cigars						
Chewing Tobacco						
Other						

2. Have you quit smoking? ☐ Yes ☐ No If yes, when? (month/year) _____

3. Does any one in your household smoke? ☐ Yes ☐ No

B. How much caffeine do you consume daily on average?

Substance	Cups per day
Coffee	
Tea	
Cola	

Family History

Describe family history.

Have any family members suffered from cardiac/stroke related conditions described on previous page? ☐ Yes ☐ No

If yes, please indicate below.

Relationship	Cardiac/Stroke/Other	Age upon death	Alive Yes	Alive No
Mother				
Father				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				

Comments

_____

_____

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

Date: Name (please print): Signature: