

Baseline Respiratory Symptoms Questionnaire (Beryllium)

Name (Last, First)		Date	
LBNL Employee #		Work Phone	

1. Do you **currently** smoke tobacco or have you smoked tobacco in the last month? Yes No

2. Have you **ever had** any of the following pulmonary or lung problems?

Yes <input type="checkbox"/> No <input type="checkbox"/> Asbestosis	Yes <input type="checkbox"/> No <input type="checkbox"/> Silicosis
Yes <input type="checkbox"/> No <input type="checkbox"/> Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/> Pneumothorax (collapsed lung)
Yes <input type="checkbox"/> No <input type="checkbox"/> Chronic bronchitis	Yes <input type="checkbox"/> No <input type="checkbox"/> Lung cancer
Yes <input type="checkbox"/> No <input type="checkbox"/> Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/> Broken ribs
Yes <input type="checkbox"/> No <input type="checkbox"/> Pneumonia	Yes <input type="checkbox"/> No <input type="checkbox"/> Any chest injuries or surgeries
Yes <input type="checkbox"/> No <input type="checkbox"/> Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/> Any other lung problem that you've been told about

3. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

Yes <input type="checkbox"/> No <input type="checkbox"/> Shortness of breath
Yes <input type="checkbox"/> No <input type="checkbox"/> Shortness of breath when walking fast on level ground or walking up a slight hill or incline
Yes <input type="checkbox"/> No <input type="checkbox"/> Shortness of breath when walking with other people at an ordinary pace on level ground
Yes <input type="checkbox"/> No <input type="checkbox"/> Have to stop for breath when walking at your own pace on level ground
Yes <input type="checkbox"/> No <input type="checkbox"/> Shortness of breath when washing or dressing yourself
Yes <input type="checkbox"/> No <input type="checkbox"/> Shortness of breath that interferes with your job
Yes <input type="checkbox"/> No <input type="checkbox"/> Coughing that produces phlegm (thick sputum)
Yes <input type="checkbox"/> No <input type="checkbox"/> Coughing that wakes you early in the morning
Yes <input type="checkbox"/> No <input type="checkbox"/> Coughing that occurs mostly when you are lying down
Yes <input type="checkbox"/> No <input type="checkbox"/> Coughing up blood in the last month
Yes <input type="checkbox"/> No <input type="checkbox"/> Wheezing
Yes <input type="checkbox"/> No <input type="checkbox"/> Wheezing that interferes with your job
Yes <input type="checkbox"/> No <input type="checkbox"/> Chest pain when you breathe deeply
Yes <input type="checkbox"/> No <input type="checkbox"/> Any other symptoms that you think may be related to lung problems

4. Do you currently take medication for any breathing or lung problems? Yes No

5. Have you worked with any of the materials, or under any of the conditions, listed below?

- Yes No Asbestos
- Yes No Silica (e.g., in sandblasting)
- Yes No Tungsten/cobalt (e.g., grinding or welding this material)
- Yes No Beryllium
- Yes No Aluminum
- Yes No Coal (for example, mining)
- Yes No Iron
- Yes No Tin
- Yes No Dusty environments
- Yes No Any other hazardous exposures

If "yes," describe these exposures:

6. List any second jobs or side business you have that involve chemical use:

7. List your current and previous hobbies that involve chemical use:

8. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes No