

Anamnesis "Mineral Dust" G 1.1, G 1.2, G 1.3

Surname	First name
Date of birth	Nationality
Address: street	
Postcode, town	

Employer
Employer's address

Job
Exposures

Examination according to the guideline	<input type="checkbox"/> G 1.1	<input type="checkbox"/> G 1.2	<input type="checkbox"/> G 1.3	Date	____.____.____
Examination	<input type="checkbox"/> initial	<input type="checkbox"/> follow-up	<input type="checkbox"/> when leaving the job		

Work anamnesis	crystalline silica	asbestos	mineral fibres
Have you been exposed to dust at work before you started work in the present firm?	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
In which year were you first exposed to dust?	_____	_____	_____
Kind of job	_____		
For how long were you or have you been exposed to dust all together? (years, months)	____ years ____ months	____ years ____ months	____ years ____ months
Have you ever stopped working at a dusty workplace because of one or more of the following symptoms?			
a) respiratory symptoms	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
b) heart problems	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes
c) problems with the circulatory system	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> yes

Symptom anamnesis				
Have you or have you had any of the following diseases?				
a) tuberculosis of the lungs	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> unsure	date of the illness	____.____.____
b) pneumonia	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> unsure	date of the illness	____.____.____
c) pleurisy	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> unsure	date of the illness	____.____.____
d) bronchitis several times a year	<input type="checkbox"/> no <input type="checkbox"/> yes		date when it began	____.____.____
e) bronchial asthma	<input type="checkbox"/> no <input type="checkbox"/> yes		date when it began	____.____.____
f) other chronic diseases?	<input type="checkbox"/> no <input type="checkbox"/> yes		date when it began	____.____.____
Which?	_____			
Do you cough during at least three months of the year?	<input type="checkbox"/> no <input type="checkbox"/> yes		date when it began	month ____ and year ____
Do you expectorate during at least three months of the year?	<input type="checkbox"/> no <input type="checkbox"/> yes		date when it began	____.____.____
a) haemoptysis (spitting blood)	<input type="checkbox"/> no <input type="checkbox"/> yes		date when it began	____.____.____
Have you noticed recently persistent hoarseness, difficulty in swallowing, the feeling of having something stuck in your throat?	<input type="checkbox"/> no <input type="checkbox"/> yes			
Do you smoke?	<input type="checkbox"/> no <input type="checkbox"/> not any longer <input type="checkbox"/> yes			
If yes or not any longer please state how many pack years*	_____			
* a pack year is about 20 cigarettes daily per year	1-10 cigarettes/day from ____ till ____ (year)	11-20 cigarettes/day from ____ till ____ (year)		
	21-40 cigarettes/day from ____ till ____ (year)	>40 cigarettes/day from ____ till ____ (year)		
	<input type="checkbox"/> pipe <input type="checkbox"/> cigars			
Have you lost weight during the last 6 months?	<input type="checkbox"/> no <input type="checkbox"/> yes			

Comments

Date, stamp, signature of the physician