WorkplaceNL

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Crab Asthma Questionnaire

- This questionnaire consists of 4 pages and must be fully completed by the worker in order for their claim to be adjudicated.
- The questionnaire must be signed by the worker.
- The completed questionnaire must be sent to WorkplaceNL along with the necessary WorkplaceNL forms.

General Information:

Name: ______________________________

Complete Mailing Address: ______________________________

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Telephone (home): ____________________ (work): ____________________

WorkplaceNL Claim # (if known): ______________________________

Social Insurance Number: ______________________________

Family Doctor: ______________________________

Occupational Questionnaire

1. Please, detail your previous jobs

Date	Industry/Company	Type of Job

2. At which plant are you currently working? ______________________________

3. Where is it located? ______________________________

4. How long have you been working at this plant? ______________________________

5. What types of jobs have you been doing at this plant? ______________________________

6. Have you been working with or close to snow crab? ☐ Yes ☐ No

   If yes, at which job and when? ______________________________

7. Have you had any respiratory symptoms (wheezing, chest tightness, coughing, or shortness of breath) or allergic symptoms (skin, nose, or eyes) in relation to this work? ☐ Yes ☐ No

   If YES, please specify: ______________________________

   ____

Medical History

The next questions relate to symptoms that you may have experienced during the last 4 weeks

Wheezing

1. Have you had wheezing or whistling in your chest at any time in the last month? ☐ Yes ☐ No
   If NO, go to question 3.

2. Do you take any drugs (such as puffers, prednisone, theophylline) to relieve this wheezing? ☐ Yes ☐ No

   If Yes, specify: ______________________________

Chest tightness

3. Do you sometimes wake up with a feeling of chest tightness first thing in the morning? ☐ Yes ☐ No
   If NO, go to question 6

4. How long does this tightness usually last for?

   ☐ less than 30 minutes ☐ 30 minutes to 1 hour ☐ more than 1 hour ☐ don't know

5. Do you use any medicines to relieve this tightness? ☐ Yes ☐ No

   If YES, please specify what medicines: ______________________________

Cough

6. In the last month, have you been awakened by coughing at night? ☐ Yes ☐ No

Shortness of breath

7. Have you at any time in the last month, had an attack of shortness of breath (difficulty breathing)? ☐ Yes ☐ No
   If NO, go to question 9

8. Did this/these attack(s) of shortness of breath come on:
   during the night ☐ Yes ☐ No during the day ☐ Yes ☐ No
   when you were doing something strenuous? ☐ Yes ☐ No
   when you were not doing anything strenuous? ☐ Yes ☐ No

9. Does exercise or strenuous work or very cold air, ever make you:
   start to cough ☐ Yes ☐ No start to wheeze ☐ Yes ☐ No
   get a feeling the chest tightness ☐ Yes ☐ No get suddenly short of breath ☐ Yes ☐ No

   If YES, please specify in which circumstances: ______________________________

10. When you are exposed to strong odors, smoke, or dust, do you ever:
    start to cough for several minutes ☐ Yes ☐ No start to wheeze ☐ Yes ☐ No
    get a feeling of tightness in your chest ☐ Yes ☐ No start to feel short of breath ☐ Yes ☐ No

    If YES, specify in which circumstances:

    ☐ strong odors ☐ smoke dust

11. Which of the following statements best describes your breathing in the last month:

☐ I rarely if ever have trouble with my breathing

☐ I do have regular trouble with my breathing, but (choose the one that applies):

☐ it always gets completely better ☐ my breathing is never quite right

Phlegm from the chest

12. Do you usually bring up phlegm from your chest first thing in the morning? ☐ Yes ☐ No
(Include phlegm with the first smoke or on first going out-of-doors. Clearing your throat does not count)

If NO, go to question 14.

13. Have you brought up phlegm from your chest like this on most mornings for at least 3 months each year?

☐ Yes ☐ No If YES, for how many years? ____________________

Past history

14. Are you being treated for any other medical conditions at the present time? ☐ Yes ☐ No

If YES, please describe:

15. List all the medicines you are taking at the current time, including puffers:

16. Have you ever had “hayfever” (attacks of sneezing with runny or stuffy nose, itching of the nose, itchy or watery eyes, coming on at certain periods of the year)? ☐ Yes ☐ No

If NO, go to question 18.

If YES, at what time of the year? ☐ Spring ☐ Summer ☐ Fall ☐ Winter

17. How old were you when you had hayfever for the first time?__________ years old

18. Have you ever been told by a doctor that you have eczema (scaling , red or pink, rash that occurs in elbow creases, behind the knees and/or sometimes behind the ears)? ☐ Yes ☐ No

If NO, go to question 20.

19. How old were you when you had it for the first time?__________ years old

20. Have you ever had hives? ☐ Yes ☐ No

If NO, go to question 23.

21. Did a doctor tell you that you had hives? ☐ Yes ☐ No

22. How old were you when you had them for the first time? __________ years old

23. Have you ever had asthma before working at this crab plant? ☐ Yes ☐ No

24. Did a doctor ever tell you that you had asthma? ☐ Yes ☐ No

25. How old were you when you had your first attack?__________ years old

Family history:

26. Has any one in your family (including parents, brothers or sisters, and children) ever been diagnosed with asthma, hayfever, eczema or hives? ☐ Yes ☐ No

If YES, please describe which family member and what condition: ______________________________

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Smoking

27. 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)? ☐ Yes ☐ No

    If NO, go to question 33

28. Do you now smoke cigarettes (as of 1 month ago)? ☐ Yes ☐ No

29. How old were you when you first started regular cigarette smoking? ________ years old

30. If you have stopped smoking cigarettes completely, how old were you when you stopped? ________ years old

31. How many cigarettes per day do you smoke now? ________ cigarettes per day

32. During the entire time you smoked, how many cigarettes did you smoke per day on average? cigarettes per day

33. Have you ever smoked a pipe regularly (YES means more than 12 oz. of tobacco in a lifetime)? ☐ Yes ☐ No

Home

34. Do you have pets at home? ☐ Yes ☐ No

    If YES, is it: ☐ cat ☐ dog ☐ bird ☐ others

35. If you are exposed to pets, do you ever:

start to cough:	☐ Yes	☐ No	start to wheeze:	☐ Yes	☐ No
get a feeling of tightness in your chest:	☐ Yes	☐ No	start to feel short of breath:	☐ Yes	☐ No
get a runny or stuffy nose:	☐ Yes	☐ No	get an attack of sneezing:	☐ Yes	☐ No
get itchy or watery eyes:	☐ Yes	☐ No	wake up at night because of a chest complaint *(cough, wheezing or shortness of breath):*	☐ Yes	☐ No
get an itch or rash on your skin:	☐ Yes	☐ No			

36. If you are exposed to house dust (vacuum cleaning, making the bed), do you ever:

start to cough:	☐ Yes	☐ No	start to wheeze:	☐ Yes	☐ No
get a feeling of tightness in your chest:	☐ Yes	☐ No	start to feel short of breath:	☐ Yes	☐ No
get a runny or stuffy nose:	☐ Yes	☐ No	get an attack of sneezing:	☐ Yes	☐ No
get itchy or watery eyes:	☐ Yes	☐ No	wake up at night because of a chest complaint *(cough, wheezing or shortness of breath):*	☐ Yes	☐ No
get an itch or rash on your skin:	☐ Yes	☐ No			

I certify that the above information is accurate and correct, to the best of my knowledge.

Signature ______________________ Date ______________________