

**CONFIDENTIAL QUESTIONNAIRE**

Date completed: \_\_\_\_\_ Referring attorney: (if applicable) \_\_\_\_\_

**How Did you find us (circle one) :** TV | Radio | Newspaper | Letter | Friends | Co-worker | Union

1.	Last name	
2.	First & middle names	
3.	Social Security #	
4.	Date & place of birth	
5.	Spouses first & middle names	
6.	Social Security #	
7.	Date & place of birth	
8.	Home street address	
9.	City, State & Zip	
10.	Home telephone:	
11.	Mailing address:	
12.	Work telephone:	
13.	Mobile telephone:	
14.	E-mail address:	

**15. DEPENDENT INFORMATION:** Please provide the names, addresses and birth dates of all children:

Name	Address	Date of birth



16. **WORK HISTORY:** List the job sites where you have worked. Give the approximate dates or years that you worked at these sites. If you worked with other local members during these times, please provide their names. Attach further pages if necessary.

Site	Years	Co-Workers

17. List the major contractors/subcontractors for whom you worked.

Contractor	Dates	Types of work

18. Which of the following welding processes have you used or which were used in close proximity to you:

#	Welding process	YES	NO
a.	Shielded Metal Arc Welding (SMAW, stick)		
b.	Gas Metal Arc Welding (GMAW, MIG)		
c.	Gas Tungsten Arc Welding (GTAW, TIG)		
d.	Flux Colored Arc Welding (FCAW)		
e.	Plasma Arc Welding (PAC, PAW)		
f.	Submerged Arc Welding (SAW)		
g.	Carbon Arc Welding (CAW)		
h.	Electro Slag Welding (ESW)		
i.	Electro Gas Welding (EGW)		
j.	Stand Welding		
k.	Oxyacetylene Welding		

l.	Beddon Plate Welding		
m.	Torch Brazing		
n.	Oxygen Cutting		
o.	Air Carbon Arc Cutting		

19. On average, how many days per week did you weld? \_\_\_\_\_

20. On average, how many hours per day did you spend welding? \_\_\_\_\_

21. Was your primary welding exposure due to being around others who welded? Yes ? No ?

If yes, how many hours were you around welders? \_\_\_\_\_

How close were you working to the welders? \_\_\_\_\_

22. Please complete the table below as appropriate.

	Check if you used these welding rods.	How often did you use their rods?		Please list rod Model numbers you worked with.
		Frequently	Occasionally	
Air Products				
Airco				
Ancos				
Alloy Rods				
Amsco				
Coast Metals				
Enterprise				
Haynes Stellite				
Hobart				
Lincoln Electric				
Lindo				
Mariquette				
McKay Co.				
Mid States				
Murex				

National Standard				
Paje				
Rankin				
Reid-Avery Co. RACO				
Rexano				
Stoody				
Tri-Mark				
Unibraze				
Victon				
Wall Comony				
Westinghouse				
Dual Shield				
Gulf Wire Corp				
Select Arc				
Spool Arc				
Atom Arc				
Shield Bright				
Magnolia Welding				

**3. SMOKING and/or ALCOHOL USAGE:**

15. Have you ever smoked? Yes ?                      No ?
16. If Yes, what year did you start smoking? \_\_\_\_\_
17. If yes, what did you smoke?
- Cigarettes        ?                      Brand Name : \_\_\_\_\_
- Cigars                ?                      How many: \_\_\_\_\_
- Pipes                 ?                      How many bowls: \_\_\_\_\_
- d. How old were you when you started smoking? \_\_\_\_\_

e. How many packs did you smoke per day? \_\_\_\_\_

f. Did you stop smoking? Yes ? No. ?

g. On average, how much alcohol do you/did you drink?

Did not drink \_\_\_\_\_  
 0 - 3 drinks per week \_\_\_\_\_ 3-6 drinks per week \_\_\_\_\_  
 6-12 drinks per week \_\_\_\_\_ 12 or more drinks per week \_\_\_\_\_

- 24. Do you experience a feeling of weakness in your legs? Yes ? No ?
- 25. Do you have difficult walking downhill? Yes ? No ?
- 26. Do you sometimes lose your balance? Yes ? No ?
- 27. Do your fingers or hands shake? Yes ? No ?
- 28. Does performing heavy work make you feel weak? Yes ? No ?
- 29. Have you noticed any changes in the way you speak? Yes ? No ?
- 30. Please circle any of the symptoms listed below that you have experienced:

Cramps in legs or arms.	Muscle rigidity or tenseness.
Increased tiredness.	Increased and abnormal reflexes.
Feelings of aggressiveness.	Irregular handwriting.
Insomnia.	Poor memory.
Mental confusion.	Impaired hearing.
Impotence.	Double Vision.
Loss of desire to talk.	Restlessness.
Irritability	Visual hallucinations.
Excessive sweating	Excessive salivation.
Headaches.	

31. Has a doctor ever diagnosed you with any of the following:

Check if applicable	Date diagnosed	Name of doctor, clinic or hospital	Address
? Parkinson=s disease			
?Parkinsonism			
?Manganism			
?Neuropathy			
?Pneumonitis			
?Asthma			
?Emphysema			
?Asbestosis			
?Silicosis			
?Heart Disease			

?Hypertension or High Blood Pressure			
? Osteoporosis			
?Anemia			
?Malaria			
?Avitaminosis			
?Liver dysfunction			

32. Have any family members ever been diagnosed with Parkinson=s Disease, Parkinson=s Syndrome or Parkinsonism? Yes ? No. ?

If yes, please list that person=s name, age at diagnosis, occupation and relationship to you.

Name: \_\_\_\_\_

Age at Diagnosis: \_\_\_\_\_ Occupation: \_\_\_\_\_

Relationship: \_\_\_\_\_