

**ASBESTOS EXPOSURE
PART I - INITIAL MEDICAL QUESTIONNAIRE**

IDENTIFICATION

1. NAME (Last, First, Middle Initial)		2. SOCIAL SECURITY NO. (1 - 9)		3. CLOCK NO. (10 - 15)		4. PRESENT OCCUPATION			
5. NAME OF PLANT			6. STREET ADDRESS OF PLANT			7. PLANT CITY, STATE AND ZIP CODE			
8. TELEPHONE NO. (Include area code)		9. NAME OF INTERVIEWER		10. DATE OF INTERVIEW (16 - 21) (YYYYMMDD)		11. DATE OF BIRTH (22 - 29) (YYYYMMDD)		12. PLACE OF BIRTH	
13. SEX (X one) <input type="checkbox"/> a. MALE <input type="checkbox"/> b. FEMALE		14. MARITAL STATUS (X one) <input type="checkbox"/> a. SINGLE <input type="checkbox"/> b. MARRIED <input type="checkbox"/> c. WIDOWED <input type="checkbox"/> d. DIVORCED/SEPARATED			15. RACE (X one) <input type="checkbox"/> a. WHITE <input type="checkbox"/> b. BLACK <input type="checkbox"/> c. ASIAN <input type="checkbox"/> d. HISPANIC <input type="checkbox"/> e. INDIAN <input type="checkbox"/> f. OTHER			16. HIGHEST GRADE COMPLETED IN SCHOOL	

MEDICAL DATA

17. OCCUPATIONAL HISTORY				Yes	No	N/A	21. DID YOU HAVE ANY LUNG TROUBLE BEFORE THE AGE OF 16?				Yes	No	N/A
a. HAVE YOU EVER WORKED FULL TIME (30 hours per week or more) FOR SIX MONTHS OR MORE?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. HAVE YOU EVER HAD ANY OF THE FOLLOWING?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. IF YES, HAVE YOU EVER WORKED FOR A YEAR OR MORE IN ANY DUSTY JOB? *If Yes, complete (1) - (3).				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. ATTACKS OF BRONCHITIS * If yes, complete (1) and (2).				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(1) Specify Job/Industry	(2) Total years worked	(3) Dust Exposure (X one)					(1) Age at first attack		(2) Was it confirmed by a doctor?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE					b. ATTACKS OF PNEUMONIA (Include bronchopneumonia) *If yes, complete (1) and (2)		(2) Was it confirmed by a doctor?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. HAVE YOU EVER BEEN EXPOSED TO GAS OR CHEMICAL FUMES IN YOUR WORK? *If Yes, complete (1) - (3).				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(1) Age at first attack		(2) Was it confirmed by a doctor?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(1) Specify Job/ Industry	(2) Total years worked	(3) Exposure (X one)					c. HAY FEVER * If yes, complete (1) and (2).		(2) Was it confirmed by a doctor?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE					23. HAVE YOU EVER HAD CHRONIC BRONCHITIS?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. WHAT HAS BEEN YOUR USUAL OCCUPATION - THE ONE YOU HAVE WORKED AT THE LONGEST?							a. IF YES, DO YOU STILL HAVE IT?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(1) Job/Occupation		(2) Number of years employed in this occupation					b. WAS IT CONFIRMED BY A DOCTOR?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(3) Position/Job Title		(4) Business, Field or Industry					c. AT WHAT AGE DID IT START? (List age)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. HAVE YOU EVER WORKED (X Yes or No and specify years worked, e.g. 1960 - 1969.)							24. HAVE YOU EVER HAD EMPHYSEMA?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(1) In a mine	Years Worked						a. IF YES, DO YOU STILL HAVE IT?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(2) In a quarry							b. WAS IT CONFIRMED BY A DOCTOR?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(3) In a foundry							c. AT WHAT AGE DID IT START? (List age)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(4) In a pottery							25. HAVE YOU EVER HAD ASTHMA?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(5) In a cotton, flax or hemp mill							a. IF YES, DO YOU STILL HAVE IT?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(6) With asbestos							b. WAS IT CONFIRMED BY A DOCTOR?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. MEDICAL HISTORY							c. AT WHAT AGE DID IT START? (List age)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. DO YOU CONSIDER YOURSELF TO BE IN GOOD HEALTH? *If No, state reason.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. IF YOU NO LONGER HAVE IT, AT WHAT AGE DID IT STOP? (List age)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. HAVE YOU ANY DEFECT OF VISION? *If Yes, state nature of defect.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. HAVE YOU EVER HAD:				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. HAVE YOU ANY HEARING DEFECT? *If Yes, state nature of defect.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. ANY OTHER CHEST ILLNESSES *If yes, please specify.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. ARE YOU SUFFERING FROM OR HAVE YOU EVER SUFFERED FROM							b. ANY CHEST OPERATIONS *If yes, please specify.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(1) Epilepsy (Or fits, seizures or convulsions)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. ANY CHEST INJURIES *If yes, please specify.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(2) Rheumatic Fever				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. HEART TROUBLE				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(3) Kidney Disease				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. HAS A DOCTOR EVER TOLD YOU THAT YOU HAD HEART TROUBLE?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(4) Bladder Disease				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. IF YES, HAVE YOU EVER HAD TREATMENT FOR HEART TROUBLE IN THE PAST TEN YEARS?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(5) Diabetes				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. HIGH BLOOD PRESSURE				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(6) Jaundice				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. HAS A DOCTOR EVER TOLD YOU THAT YOU HAD HIGH BLOOD PRESSURE (Hypertension)?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. IF YOU GET A COLD, DOES IT USUALLY GO TO YOUR CHEST? (Usually means more than 1/2 of the time)*Don't get colds				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. IF YES, HAVE YOU EVER HAD TREATMENT FOR HIGH BLOOD PRESSURE IN THE PAST TEN YEARS?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. CHEST ILLNESSES							29. WHEN DID YOU LAST HAVE YOUR CHEST X-RAYED? (Year)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. DURING THE PAST THREE YEARS, HAVE YOU HAD ANY CHEST ILLNESSES THAT HAVE KEPT YOU OFF WORK, INDOORS AT HOME, OR IN BED?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. CHEST X-RAY				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. IF YES, DID YOU PRODUCE PHLEGM WITH ANY OF THESE ILLNESSES?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. WHERE DID YOU LAST HAVE YOUR CHEST X-RAYED? (If known)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. IN THE LAST THREE YEARS, HOW MANY SUCH ILLNESSES WITH INCREASED PHLEGM DID YOU HAVE WHICH LASTED A WEEK OR MORE? (List number)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. WHAT WAS THE OUTCOME?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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MEDICAL DATA (Continued)

31. WERE EITHER OF YOUR NATURAL PARENTS TOLD THAT THEY HAD A CHRONIC LUNG CONDITION SUCH AS		Father			Mother			38. BREATHLESSNESS			Yes	No	N/A
		Yes	No	Don't Know	Yes	No	Don't Know	a. ARE YOU TROUBLED BY SHORTNESS OF BREATH WHEN HURRYING ON THE LEVEL OR WALKING UP A SLIGHT HILL?					
a. CHRONIC BRONCHITIS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. IF YES, DO YOU HAVE TO WALK SLOWER THAN PEOPLE OF YOUR AGE ON THE LEVEL BECAUSE OF BREATHLESSNESS?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. EMPHYSEMA		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. DO YOU EVER HAVE TO STOP FOR BREATH WHEN WALKING AT YOUR OWN PACE ON THE LEVEL?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. ASTHMA		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. DO YOU EVER HAVE TO STOP FOR BREATH AFTER WALKING ABOUT 100 YARDS (or after a few minutes) ON THE LEVEL?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. LUNG CANCER		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. ARE YOU TOO BREATHLESS TO LEAVE THE HOUSE OR BREATHLESS ON DRESSING OR CLIMBING ONE FLIGHT OF STAIRS?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. OTHER CHEST CONDITIONS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. CIGARETTE SMOKING					
f. IS PARENT CURRENTLY ALIVE?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. 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.			<input type="checkbox"/>	<input type="checkbox"/>	*
g. Please specify		AGE IF LIVING		<input type="checkbox"/>	AGE AT DEATH		<input type="checkbox"/>	b. IF YES, DO YOU NOW SMOKE CIGARETTES? (As of one month ago)?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CAUSE OF DEATH	Father:	<input type="checkbox"/>	Mother:		<input type="checkbox"/>			c. HOW OLD WERE YOU WHEN YOU FIRST STARTED REGULAR CIGARETTE SMOKING? (Number of years)					<input type="checkbox"/>
32. COUGH								d. IF YOU HAVE STOPPED SMOKING CIGARETTES COMPLETELY, HOW OLD WERE YOU WHEN YOU STOPPED? (List age in (1) or X (2))					<input type="checkbox"/>
a. DO YOU USUALLY HAVE A COUGH? (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.) *If No, skip to question 32.c.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*	(1) Age in years <input type="checkbox"/> (2) Still smoking					<input type="checkbox"/>
b. DO YOU USUALLY COUGH AS MUCH AS FOUR TO SIX TIMES A DAY FOUR OR MORE DAYS OUT OF THE WEEK?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		e. HOW MANY CIGARETTES DO YOU SMOKE PER DAY NOW?					<input type="checkbox"/>
c. DO YOU USUALLY COUGH AT ALL ON GETTING UP OR FIRST THING IN THE MORNING?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		f. ON THE AVERAGE OF THE ENTIRE TIME YOU SMOKED, HOW MANY CIGARETTES DID YOU SMOKE PER DAY?					<input type="checkbox"/>
d. DO YOU USUALLY COUGH AT ALL DURING THE REST OF THE DAY OR AT NIGHT?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		g. DO OR DID YOU INHALE CIGARETTE SMOKE (X one)					<input type="checkbox"/>
IF YES TO ANY OF ABOVE (32.a., b., c., or d.), ANSWER THE FOLLOWING. IF NO TO ALL, X "N/A" AND SKIP TO ITEM 33.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		(1) Not at all <input type="checkbox"/> (2) Slightly <input type="checkbox"/> (3) Moderately <input type="checkbox"/> (4) Deeply					<input type="checkbox"/>
e. DO YOU USUALLY COUGH LIKE THIS ON MOST DAYS FOR THREE CONSECUTIVE MONTHS OR MORE DURING THE YEAR?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		40. PIPE SMOKING					
f. FOR HOW MANY YEARS HAVE YOU HAD THE COUGH?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		a. HAVE YOU EVER SMOKED A PIPE REGULARLY? *Yes means more than 12 oz. of tobacco in a lifetime.			<input type="checkbox"/>	<input type="checkbox"/>	*
33. PHLEGM								b. HOW OLD WERE YOU WHEN YOU FIRST STARTED PIPE SMOKING? (Number of years)					<input type="checkbox"/>
a. DO YOU USUALLY BRING UP PHLEGM FROM YOUR CHEST? (Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) *If No, skip to Item 33.c.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*	c. IF YOU HAVE STOPPED SMOKING A PIPE COMPLETELY, HOW OLD WERE YOU WHEN YOU STOPPED? (List age in (1) or X (2))					<input type="checkbox"/>
b. DO YOU USUALLY BRING UP PHLEGM LIKE THIS AS MUCH AS TWICE A DAY FOUR OR MORE DAYS OUT OF THE WEEK?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		(1) Age in years <input type="checkbox"/> (2) Still smoking					<input type="checkbox"/>
c. DO YOU USUALLY BRING UP PHLEGM AT ALL ON GETTING UP OR FIRST THING IN THE MORNING?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		d. ON THE AVERAGE OF THE ENTIRE TIME YOU SMOKED, HOW MUCH PIPE TOBACCO DID YOU SMOKE PER WEEK? (Oz. per week - a standard pouch of tobacco contains 1 1-1/2 oz.)					<input type="checkbox"/>
d. DO YOU USUALLY BRING UP PHLEGM AT ALL DURING THE REST OF THE DAY OR AT NIGHT?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		e. HOW MUCH PIPE TOBACCO DO YOU SMOKE PER WEEK NOW?					<input type="checkbox"/>
IF YES TO ANY OF ABOVE (33.a., b., c., or d.), ANSWER THE FOLLOWING. IF NO TO ALL, X "N/A" AND SKIP TO ITEM 34.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		f. DO OR DID YOU INHALE PIPE SMOKE (X one)					<input type="checkbox"/>
e. DO YOU USUALLY BRING UP PHLEGM LIKE THIS ON MOST DAYS FOR THREE CONSECUTIVE MONTHS OR MORE DURING THE YEAR?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		(1) Not at all <input type="checkbox"/> (2) Slightly <input type="checkbox"/> (3) Moderately <input type="checkbox"/> (4) Deeply					<input type="checkbox"/>
f. FOR HOW MANY YEARS HAVE YOU HAD TROUBLE WITH PHLEGM?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		41 CIGAR SMOKING					
34. EPISODES OF COUGH AND PHLEGM								a. HAVE YOU EVER SMOKED CIGARS REGULARLY? *Yes means more than 1 cigar a week for a year.			<input type="checkbox"/>	<input type="checkbox"/>	*
a. HAVE YOU HAD PERIODS OR EPISODES OF (increased*) COUGH AND PHLEGM LASTING FOR THREE WEEKS OR MORE EACH YEAR? *For persons who usually have cough and/or phlegm		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		b. HOW OLD WERE YOU WHEN YOU FIRST STARTED REGULAR CIGAR SMOKING? (Number of years)					<input type="checkbox"/>
b. FOR HOW LONG HAVE YOU HAD AT LEAST ONE SUCH EPISODE PER YEAR? (Number of years)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		c. IF YOU HAVE STOPPED SMOKING CIGARS COMPLETELY, HOW OLD WERE YOU WHEN YOU STOPPED? (List age in (1) or X (2))					<input type="checkbox"/>
35. WHEEZING/WHISTLING								(1) Age in years <input type="checkbox"/> (2) Still smoking					<input type="checkbox"/>
a. DOES YOUR CHEST EVER SOUND WHEEZY OR WHISTLING								d. ON THE AVERAGE OF THE ENTIRE TIME YOU SMOKED, HOW MANY CIGARS DID YOU SMOKE PER WEEK?					<input type="checkbox"/>
(1) When you have a cold		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		e. HOW MANY CIGARS DO YOU SMOKE PER WEEK NOW?					<input type="checkbox"/>
(2) Occasionally apart from colds		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		f. DO OR DID YOU INHALE CIGAR SMOKE (X one)					<input type="checkbox"/>
(3) Most days or nights		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		(1) Not at all <input type="checkbox"/> (2) Slightly <input type="checkbox"/> (3) Moderately <input type="checkbox"/> (4) Deeply					<input type="checkbox"/>
b. IF YES TO 35.a.(1), (2) or (3), FOR HOW MANY YEARS HAS THIS BEEN PRESENT (Number of years)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		43. SIGNATURE			44. DATE SIGNED (YYYYMMDD)		
36. WHEEZING/SHORTNESS OF BREATH													
a. HAVE YOU EVER HAD AN ATTACK OF WHEEZING THAT HAS MADE YOU FEEL SHORT OF BREATH?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
b. IF YES, HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST SUCH ATTACK? (Number of years)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
c. HAVE YOU HAD TWO OR MORE SUCH EPISODES?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
d. HAVE YOU EVER REQUIRED MEDICINE OR TREATMENT FOR THE(SE) ATTACKS?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
37. IF DISABLED FROM WALKING BY ANY CONDITION OTHER THAN HEART OR LUNG DISEASE, PLEASE DESCRIBE NATURE OF CONDITION(S) AND PROCEED TO QUESTION 39.a.													