

BNSF Return To Work Medical Questionnaire for Prolonged, Non Work-Related Absences

Employee ID # _____

Section I - Please Print	
Name: _____	Today's Date: _____
Employee ID#: _____	Job Title: _____
Birth Date: _____	Telephone # _____
Street Address: _____	
City: _____	State: _____ Zip Code: _____

Section II

All Questions must be answered completely; explain "YES" answers in section # 24.

1 Do you currently have any of the following?	
a. Seizures (fits) [If yes, date of last seizure _____]	YES NO
b. Diabetes (sugar disease) Insulin Use ____ Oral Medication ____ Diet ____	YES NO
c. Allergic reactions that interfere with your breathing (____ Bee Stings)	YES NO
d. Claustrophobia (fear of closed-in places that affect respirator use)	YES NO
e. Sleep disorder/sleep apnea/narcolepsy; If 'yes', how treated?	YES NO
2 Since you last worked at BNSF, have you had any of the following?	
If any "yes" answers, please elaborate in Section # 24	
a. illness or injury causing > 2 day absence from daily activities	YES NO
b. hospitalization	YES NO
c. surgery	YES NO
3 Do you currently smoke tobacco, or have you smoked tobacco in the last month?	YES NO
If YES, # packs/day _____ # years smoked _____ # years quit _____ pipe/cigar _____	
4 Since you last worked at BNSF, have you had or have you been diagnosed with	
a. Asbestosis	YES NO
b. Asthma	YES NO
c. Chronic bronchitis	YES NO
d. Emphysema	YES NO
e. Pneumonia	YES NO
f. Tuberculosis	YES NO
Positive TB skin test? If yes? What is the date? _____	YES NO
If yes, did you receive treatment?	YES NO
g. Silicosis	YES NO
h. Pneumothorax (collapsed lung)	YES NO
i. Lung cancer	YES NO
j. Broken ribs	YES NO
k. Any chest injuries or surgeries	YES NO
l. Any other lung problems that you've been told about	YES NO
5 Do you currently have any of the following symptoms of pulmonary or lung illness?	
a. Shortness of breath or wheezing which interferes with work or daily activities	YES NO
b. Chronic cough	YES NO
c. Any other symptoms that you think may be related to lung problems	YES NO
6 Since you last worked at BNSF, have you had a chest x ray?	YES NO
7 Since you last worked as BNSF, have you had surgery of the arterities, coronary artery bypass, angioplasty, stent, pacemaker implanted, or intracardiac defibrillator implanted?	YES NO
8 Since you last worked at BNSF, have you been treated or sought counseling for	
a. Alcohol dependence or abuse	YES NO
b. Drug dependence or abuse	YES NO
c. Nervous condition which could impair your judgment	YES NO
d. Migraine or other chronic/recurrent headache condition?	YES NO
e. Any treatment for drug or alcohol problems (in- or out-patient)	YES NO

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<p>9 Since you last worked at BNSF, have you had or been diagnosed with (if 'yes' to any, please describe in Section # 24)</p>				
a. Heart attack	YES NO			
b. Stroke	YES NO			
c. Angina	YES NO			
d. Heart failure	YES NO			
e. Swelling in your legs or feet (not caused by walking)	YES NO			
f. Heart arrhythmia (heart beating irregularly)	YES NO			
<p>If "yes" to "f", answer these questions:</p> <p>When you have the irregular heart rhythm, do you have:</p>	n/a			
a. dizziness	YES NO			
b. shortness of breath	YES NO			
c. difficulty doing activities	YES NO			
g. Frequent pain or tightness in your chest	YES NO			
h. Pain or tightness in your chest during physical activity	YES NO			
i. High blood pressure	YES NO			
j. Any other heart problem that you've been told about since you last worked at BNSF?	YES NO			
k. heat stroke	YES NO			
<p>10 Do you currently take medications for any of the following problems?</p>				
a. Breathing or lung problems	YES NO			
b. Heart trouble	YES NO			
c. Blood pressure	YES NO			
d. Seizures (fits)	YES NO			
If yes, list medications				
<p>e. Are you taking any other medications, including over the counter medication? YES NO</p> <p>If 'yes' please list below:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Name</td> <td style="width: 30%;">Strength</td> <td style="width: 40%;">Reason for taking medication</td> </tr> </table>		Name	Strength	Reason for taking medication
Name	Strength	Reason for taking medication		
<p>11 Since you last worked for BNSF, has your ability to perform daily activities been affected by pain, swelling, soreness, weakness, or difficulty moving your: (If 'yes', describe in Section # 24.)</p>				
a. Neck?	YES NO			
b. Shoulders?	YES NO			
c. Arms? Elbows? Wrists? Hands?	YES NO			
d. Fingers?	YES NO			
e. Upper or Lower Back?	YES NO			
f. Hip?	YES NO			
g. Knees? Legs? Ankles? Feet?	YES NO			

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12 Since you last worked for BNSF, have you had a back injury?	YES	NO
13 Since you last worked for BNSF, have you had or been diagnosed with any of the following?		
a. Arthritis (rheumatoid arthritis, osteoarthritis, gout)?	YES	NO
b. Carpal Tunnel or Cubital Tunnel Syndrome?	YES	NO
c. Tendonitis or Bursitis?	YES	NO
d. Recurrent Shoulder Dislocations?	YES	NO
e. Herniated Disc Disease (neck or back)	YES	NO
14 Do you currently have any of the following musculoskeletal problems?		
a. Pain or stiffness when you lean forward or backward at the waist	YES	NO
b. Difficulty fully moving your head up or down	YES	NO
c. Difficulty squatting to the ground?	YES	NO
d. Difficulty climbing stairs or a ladder?	YES	NO
e. Difficulty raising your arms above your head?	YES	NO
f. Difficulty pushing, pulling, or carrying more than 25 lbs.?	YES	NO
15 Do you currently have any of the following?		
a. Liver disease, kidney disease, pancreatic disease or anemia?	YES	NO
16 Since you last worked for BNSF, have you lost vision in either eye temporarily or permanently?	YES	NO
17 Do you currently have any of the following vision problems?		
a. Wear contact lenses and/or glasses	YES	NO
b. Color blindness or color recognition deficit	YES	NO
c. Recovering from recent eye surgery	YES	NO
d. Any other eye or vision problem	YES	NO
18 Since you last worked for BNSF, have you had		
a. any injury to your ear(s), including a broken ear drum?	YES	NO
b. daily or weekly exposure to excessive noise?	YES	NO
19 Do you currently have any of the following hearing problems?		
a. Difficulty hearing or any other ear or hearing problem?	YES	NO
b. Wear a hearing aid	YES	NO
20 Since you last worked at BNSF, have you have any of the following?		
If "yes", please elaborate in Section # 24.		
a. Brain disease or tumor?	YES	NO
b. Skull injury/fracture, been knocked unconsciousness or had a concussion?	YES	NO
c. Fainting spells or loss of consciousness?	YES	NO
d. Problems with balance or dizziness?	YES	NO
21 Are you returning from a military leave?	YES	NO
If "YES", were you injured or did you contract an illness during military service?	YES	NO
If 'yes', please describe the nature of the illness/injury _____		

If 'yes', do you have a Veteran's Administration Disability Rating?	YES	NO
If 'yes', what is the percentage (%) of the disability? _____		
22 Do you intend to apply for a VA disability rating?	YES	NO
23 Have you had other employment since you last worked for BNSF?	YES	NO
If "YES", have you been injured in an on-the-job accident or have you filed a claim against the employer for medical benefits or other compensation?	YES	NO
If 'yes', please state		
a. nature of injury _____		
b. date on injury _____		
c. state in which you filed your claim _____		
d. impairment rating (%) you were given, if any, by either a physician or a court _____		
e. date of final settlement, if you settled out of court _____		
f. date of final judgement, if a court ruled in your favor _____		

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