

Appendix D to §1910.1001 - Medical Questionnaires - Mandatory

This mandatory appendix contains the medical questionnaires that must be administered to all employees who are exposed to asbestos above the permissible exposure limit, and who will therefore be included in their employer's medical surveillance program. Part 1 of the appendix contains the Initial Medical Questionnaire, which must be obtained for all new hires who will be covered by the medical surveillance requirements. Part 2 includes the abbreviated Periodical Medical Questionnaire, which must be administered to all employees who are provided periodic medical examinations under the medical surveillance provisions of the standard.

Part 1

INITIAL MEDICAL QUESTIONNAIRE:

1. NAME: _____
2. SOCIAL SECURITY NUMBER: _____
3. CLOCK NUMBER: _____
4. PRESENT OCCUPATION: _____
5. PLANT: _____
6. ADDRESS: _____
7. CITY: _____ ST: _____ ZIP CODE: _____
8. TELEPHONE NUMBER: (_____) _____ - _____ EXT. _____
9. INTERVIEWER: _____
10. DATE: ____ / ____ / ____
11. Date of birth: ____ / ____ / ____
Month Day Year

12. Place of birth: _____

13. Sex: 1. Male 2. Female
14. What is your marital status? 1. Single 2. Married 3. Widowed 4. Separated/Divorced
15. Race: 1. White 2. Black 3. Asian 4. Hispanic 5. Indian 6. Other _____
16. What is the highest grade completed in school? ____ (For example 12 years is completion of high school)

17. OCCUPATIONAL HISTORY

- A. Have you ever worked full time (30 hours per week or more) for 6 months or more?: 1. Yes 2. No IF YES TO 17A:
B. Have you ever worked for a year or more in any dusty job? 1. Yes 2. No 3. Does Not Apply

Specify job/industry: _____ Total Years Worked: _____

Was dust exposure: 1. Mild 2. Moderate 3. Severe

- C. Have you ever been exposed to gas or chemical fumes in your work? 1. Yes 2. No

Specify job/industry: _____ Total Years Worked: _____

Was exposure: 1. Mild 2. Moderate 3. Severe

- D. What has been your usual occupation or job - the one you have worked at the longest?

1. Job occupation: _____

2. Number of years employed in this occupation: _____

3. Position/job title: _____

4. Business, field or industry: _____

(Record on lines the years in which you have worked in any of these industries, e.g. 1960-1969)

Have you ever worked:

- | | | | |
|-------------------------------------|------------------------------|-----------------------------|---------------|
| E. In a mine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ - _____ |
| F. In a quarry? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ - _____ |
| G. In a foundry? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ - _____ |
| H. In a pottery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ - _____ |
| I. In a cotton, flax, or hemp mill? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ - _____ |
| J. With asbestos? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ - _____ |

18. PAST MEDICAL HISTORY

- A. Do you consider yourself to be in good health? Yes No If "No", state reason: _____

B. Have you any defect of vision? Yes No If "Yes", state nature of defect: _____

C. Have you any hearing defect? Yes No If "Yes", state nature of defect: _____

- D. Are you suffering from or have you ever suffered from:

a. Epilepsy (or fits, seizures, convulsions)? Yes No

b. Rheumatic fever? Yes No

c. Kidney disease? Yes No

d. Bladder disease? Yes No

e. Diabetes? Yes No

f. Jaundice? Yes No

19. CHEST COLDS AND CHEST ILLNESSES:

- 19A. If you get a cold, does it *usually* go to your chest? (Usually means more than 1/2 the time): 1. Yes 2. No 3. Don't get colds

20A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? 1. Yes 2. No IF YES TO 20A:

B. Did you produce phlegm with any of these chest illnesses? 1. Yes 2. No 3. Does Not Apply

C. In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more? _____ Number of illnesses No such illnesses

21. Did you have any lung trouble before the age of 16? 1. Yes 2. No

Appendix D to §1910.1001 - Medical Questionnaires - Mandatory (Continued)

Part 1 (Continued)

EPISODES OF COUGH AND PHLEGM

34A. Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year?

*(For persons who usually have cough and/or phlegm)

IF YES TO 34A:

B. For how long have you had at least 1 such episode per year?

1. 2.

No. of Years

Does Not Apply

WHEEZING

35A. Does your chest ever sound wheezy or whistling:

1. When you have a cold?

1. 2.

2. Occasionally apart from colds?

1. 2.

3. Most days or nights?

1. 2.

IF YES TO 1, 2, or 3 in 35A

B. For how many years has this been present?

No. of Years

Does Not Apply

36A. Have you ever had an attack of wheezing that has made you feel short of breath?

1. 2.

IF YES TO 36A

B. How old were you when you had your first such attack?

Age in Years

Does Not Apply

C. Have you had 2 or more such episodes?

1. 2. 3.

D. Have you ever required medicine or treatment for the(se) attack(s)

1. 2. 3.

BREATHLESSNESS

37. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 39A.

Nature of condition(s):

38A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

1. 2.

IF YES TO 3

B. 1. 2. 3.

C. 1. 2. 3.

D. 1. 2. 3.

E. 1. 2. 3.

FOR PERSONS WHO HAVE EVER SMOKED A PIPE

B. 1. How old were you when you started to smoke a pipe regularly? _____ Age in Years

2. If you have stopped smoking a pipe completely, how old were you when you stopped? _____ Age Stopped Still Smoking Pipe Does Not Apply

C. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week?

_____ Oz. Per Week (a standard pouch of tobacco contains 1 1/2 oz.) Does Not Apply

D. How much pipe tobacco are you smoking now? _____ Oz. Per Week Not Currently Smoking A Pipe

E. Do you or did you inhale the pipe smoke? 1. Never Smoked 2. Not At All 3. Slightly 4. Moderately 5. Deeply

41A. Have you ever smoked cigars regularly? (Yes means more than 1 cigar a week for a year) 1. Yes 2. No

IF YES TO 41A:

FOR PERSONS WHO HAVE EVER SMOKED CIGARS

B. 1. How old were you when you started smoking cigars regularly? _____ Age in Years

2. If you have stopped smoking cigars completely, how old were you when you stopped? _____ Age Stopped Still Smoking Cigars Does Not Apply

C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week? _____ Cigars Per Week Does Not Apply

D. How many cigars are you smoking per week now? _____ Cigars Per Week Not Currently Smoking Cigars

E. Do or did you inhale the cigar smoke? 1. Never Smoked 2. Not At All 3. Slightly 4. Moderately 5. Deeply

Date: _____ / _____ / _____

Signature