

**Appendix B for §1910.1052**  
**Questionnaire For Methylene Chloride Exposure**

**I. DEMOGRAPHIC INFORMATION**

1. NAME: \_\_\_\_\_ 2. SOCIAL SECURITY NUMBER: \_\_\_\_\_  
3. DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 4. DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 5. AGE: \_\_\_\_\_  
MONTH DAY YEAR MONTH DAY YEAR  
6. PRESENT OCCUPATION: \_\_\_\_\_  
7. SEX:  M  F 8. RACE: \_\_\_\_\_

**II. OCCUPATIONAL HISTORY**

1. Have you ever worked with methylene chloride, dichloromethane, methylene dichloride, or CH<sub>2</sub>Cl<sub>2</sub> (all are different names for the same chemical)?  Yes  No  
Please list which on the occupational history form if you have not already.
2. If you have worked in any of the following industries and have not listed them on the occupational history form, please do so.
- |                                       |  |  |  |
|---------------------------------------|--|--|--|
| Furniture stripping                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any industry in which you used solvents to clean and degrease equipment or parts | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Polyurethane foam manufacturing       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Construction, especially painting and refinishing                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical manufacturing or formulation | <input type="checkbox"/> Yes <input type="checkbox"/> No | Aerosol manufacturing  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pharmaceutical manufacturing          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any industry in which you used aerosol adhesives                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
3. If you have not listed hobbies or household projects on the occupational history form, especially furniture refinishing, spray painting, or paint stripping, please do so.

**III. MEDICAL HISTORY**

**A. General**

1. Do you consider yourself to be in good health? If no, state reason(s). \_\_\_\_\_  
2. Do you or have you ever had:  
a.  Persistent thirst b.  Frequent urination (three times or more at night) c.  Dermatitis or irritated skin d.  Non-healing wounds  
3. What prescription or non-prescription medications do you take, and for what reasons? \_\_\_\_\_  
4. Are you allergic to any medications, and what type of reaction do you have? \_\_\_\_\_

**B. Respiratory**

1. Do you have or have you ever had any chest illnesses or diseases? Explain: \_\_\_\_\_  
2. Do you have or have you ever had any of the following: a.  Asthma b.  Wheezing c.  Shortness of breath  
3. Have you ever had an abnormal chest X-ray?  Yes  No  
If so, when, where, and what were the findings? \_\_\_\_\_  
4. Have you ever had difficulty using a respirator or breathing apparatus?  Yes  No  
Explain: \_\_\_\_\_  
5. Do any chest or lung diseases run in your family?  Yes  No  
Explain: \_\_\_\_\_  
6. Have you ever smoked cigarettes, cigars, or a pipe?  Yes  No Age started: \_\_\_\_\_  
7. Do you now smoke?  Yes  No  
8. If you have stopped smoking completely, how old were you when you stopped? \_\_\_\_\_  
9. On the average of the entire time you smoked, how many packs of cigarettes, cigars, or bowls of tobacco did you smoke per day? \_\_\_\_\_

**C. Cardiovascular**

1. Have you ever been diagnosed with any of the following: Which of the following apply to you now or did apply to you at some time in the past, even if the problem is controlled by medication? Please explain any yes answers (i.e., when problem was diagnosed, length of time on medication).
- a. High cholesterol or triglyceride level  Yes  No  
Explain: \_\_\_\_\_
- b. Hypertension (high blood pressure)  Yes  No  
Explain: \_\_\_\_\_
- c. Diabetes  Yes  No  
Explain: \_\_\_\_\_
- d. Family history of heart attack, stroke, or blocked arteries  Yes  No  
Explain: \_\_\_\_\_
2. Have you ever had chest pain?  Yes  No If so, answer the next five questions.
- a. What was the quality of the pain (i.e., crushing, stabbing, squeezing)? \_\_\_\_\_  
b. Did the pain go anywhere (i.e., into jaw, left arm)? \_\_\_\_\_  
c. What brought the pain out? \_\_\_\_\_  
d. How long did it last? \_\_\_\_\_  
e. What made the pain go away? \_\_\_\_\_
3. Have you ever had heart disease, a heart attack, stroke, aneurysm, or blocked arteries anywhere in your body?  Yes  No  
Explain (when, treatment): \_\_\_\_\_
4. Have you ever had bypass surgery for blocked arteries in your heart or anywhere else?  Yes  No  
Explain: \_\_\_\_\_
5. Have you ever had any other procedures done to open up a blocked artery (balloon angioplasty, carotid endarterectomy, clot-dissolving drug)?  Yes  No  
Explain: \_\_\_\_\_

**Appendix B to §1910.1052**  
**Questionnaire For Methylene Chloride Exposure (Continued)**

**C. Cardiovascular (continued)**

6. Do you have or have you ever had (explain each):

a. Heart murmur  Yes  No

Explain: \_\_\_\_\_

b. Irregular heartbeat  Yes  No

Explain: \_\_\_\_\_

c. Shortness of breath while lying flat  Yes  No

Explain: \_\_\_\_\_

d. Congestive heart failure  Yes  No

Explain: \_\_\_\_\_

e. Ankle swelling  Yes  No

Explain: \_\_\_\_\_

f. Recurrent pain anywhere below the waist while walking  Yes  No

Explain: \_\_\_\_\_

7. Have you ever had an electrocardiogram (EKG)?  Yes  No

When? DATE: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

8. Have you ever had an abnormal EKG?  Yes  No

If so, when, where, and what were the findings? \_\_\_\_\_

9. Do any heart diseases, high blood pressure, diabetes, high cholesterol, or high triglycerides run in your family?  Yes  No

Explain: \_\_\_\_\_

**D. Hepatobiliary and Pancreas**

1. Do you now or have you ever drunk alcoholic beverages?  Yes  No Age Started \_\_\_\_\_ Age Stopped \_\_\_\_\_

2. Average numbers per week:

a. Beers: \_\_\_\_\_, ounces in usual container: \_\_\_\_\_

b. Glasses of wine: \_\_\_\_\_, ounces per glass: \_\_\_\_\_

c. Drinks: \_\_\_\_\_, ounces in usual container: \_\_\_\_\_

3. Do you have or have you ever had (explain each):

a. Hepatitis (infectious, autoimmune, drug-induced, or chemical)  Yes  No

Explain: \_\_\_\_\_

b. Jaundice  Yes  No

Explain: \_\_\_\_\_

c. Elevated liver enzymes or elevated bilirubin  Yes  No

Explain: \_\_\_\_\_

d. Liver disease or cancer  Yes  No

Explain: \_\_\_\_\_

**E. Central Nervous System**

1. Do you or have you ever had (explain each):

a. Headache  Yes  No

Explain: \_\_\_\_\_

b. Dizziness  Yes  No

Explain: \_\_\_\_\_

c. Fainting  Yes  No

Explain: \_\_\_\_\_

d. Loss of consciousness  Yes  No

Explain: \_\_\_\_\_

e. Garbled speech  Yes  No

Explain: \_\_\_\_\_

f. Lack of balance  Yes  No

Explain: \_\_\_\_\_

g. Mental/psychiatric illness  Yes  No

Explain: \_\_\_\_\_

h. Forgetfulness  Yes  No

Explain: \_\_\_\_\_

**F. Hematologic**

1. Do you have, or have you ever had (explain each):

a. Anemia  Yes  No

Explain: \_\_\_\_\_

b. Sickle cell disease or trait  Yes  No

Explain: \_\_\_\_\_

c. Glucose-6-phosphate dehydrogenase deficiency  Yes  No

Explain: \_\_\_\_\_

d. Bleeding tendency disorder  Yes  No

Explain: \_\_\_\_\_

2. If not already mentioned previously, have you ever had a reaction to sulfa drugs or to drugs used to prevent or treat malaria?  Yes  No

What was the drug? Describe the reaction: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_