# §5202. Methylene Chloride, Appendix B
# Questionnaire For Methylene Chloride Exposure

## I. DEMOGRAPHIC INFORMATION

1. NAME: _____ 2. SOCIAL SECURITY NUMBER: ___-___-____
3. DATE: ___ — ___ — ___ (MONTH DAY YEAR) 4. DATE OF BIRTH: ___ / ___ / ___ (MONTH DAY YEAR) 5. AGE: ___
6. PRESENT OCCUPATION: _____
7. SEX: ☐ M ☐ F 8. RACE: ☐ W ☐ N ☐ IND ☐ OTHER

## II. OCCUPATIONAL HISTORY

1. Have you ever worked with methylene chloride, dichloromethane, methylene dichloride, or $CH_2Cl_2$ (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 | ☐ Yes ☐ No |
| Polyurethane foam manufacturing | ☐ Yes ☐ No |
| Chemical manufacturing or formulation | ☐ Yes ☐ No |
| Pharmaceutical manufacturing | ☐ Yes ☐ No |
| Any industry in which you used solvents to clean and degrease equipment or parts | ☐ Yes ☐ No |
| Construction, especially painting and refinishing | ☐ Yes ☐ No |
| Aerosol manufacturing | ☐ Yes ☐ No |
| Any industry in which you used aerosol adhesives | ☐ Yes ☐ 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, ☐ Yes ☐ No 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): _____

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## Questionnaire For Methylene Chloride Exposure (Continued)

**C. Cardiovascular (continued)**

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: _____
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: _____