Appendix D to §1910.1048
Medical Disease Questionnaire (non-mandatory)

A. IDENTIFICATION

PLANT NAME: _____ DATE: ____ — ____ — ____
MONTH DAY YEAR

EMPLOYEE NAME: _____

JOB TITLE: _____

BIRTHDATE: ____ / ____ / ____ AGE: ____ SEX: M ○ F ○ HEIGHT: ___ FEET ____ INCHES WEIGHT: ____ LBS.
MONTH DAY YEAR

B. MEDICAL HISTORY

1. Have you ever been in the hospital as a patient? ○ Yes ○ No
   If yes, what kind of problem were you having? _____
2. Have you ever had any kind of operation? ○ Yes ○ No
   If yes, what kind? _____
3. Do you take any kind of medicine regularly? ○ Yes ○ No
   If yes, what kind? _____
4. Are you allergic to any drugs, foods, or chemicals? ○ Yes ○ No
   If yes, what kind of allergy is it? _____
   What causes the allergy? _____
5. Have you ever been told that you have asthma, hayfever, or sinusitis? ○ Yes ○ No
6. Have you ever been told that you have emphysema, bronchitis, or any other respiratory problems? ○ Yes ○ No
7. Have you ever been told that you had hepatitis? ○ Yes ○ No
8. Have you ever been told that you had cirrhosis? ○ Yes ○ No
9. Have you ever been told that you had cancer? ○ Yes ○ No
10. Have you ever had arthritis or joint pain? ○ Yes ○ No
11. Have you ever been told that you had high blood pressure? ○ Yes ○ No
12. Have you ever had a heart attack or heart trouble? ○ Yes ○ No

B-1. MEDICAL HISTORY UPDATE

1. Have you been in the hospital as a patient any time within the past year? ○ Yes ○ No
   If so, for what condition? _____
2. Have you been under the care of a physician during the past year? ○ Yes ○ No
   If so, for what condition? _____
3. Is there any change in your breathing since last year? ○ Yes ○ No
   ○ Better? ○ Worse? ○ No change?
   If change, do you know why? _____
4. Is your general health different this year from last year? ○ Yes ○ No
   If different, in what way? _____
5. Have you in the past year or are you now taking any medication on a regular basis? ○ Yes ○ No
   Name Rx _____
   Condition being treated: _____

C. OCCUPATIONAL HISTORY

1. How long have you worked for your present employer? _____
2. What jobs have you held with this employer? Include job title and length of time in each job. _____
3. In each of these jobs, how many hours a day were you exposed to chemicals? ____
4. What chemicals have you worked with most of the time? _____
5. Have you ever noticed any type of skin rash you feel was related to your work? ○ Yes ○ No
6. Have you ever noticed that any kind of chemical makes you cough? ○ Yes ○ No Wheeze? ○ Yes ○ No
   Become short of breath or cause your chest to become tight? ○ Yes ○ No
7. Are you exposed to any dust or chemicals at home? ○ Yes ○ No
   If yes, explain: _____
8. In other jobs, have you ever had exposure to:
   Wood dust? ○ Yes ○ No Nickel or chromium? ○ Yes ○ No Silica (foundry, sand blasting)? ○ Yes ○ No
   Arsenic or asbestos? ○ Yes ○ No Organic solvents? ○ Yes ○ No Urethane foams? ○ Yes ○ No

C-1. OCCUPATIONAL HISTORY UPDATE

1. Are you working on the same job this year as you were last year? ○ Yes ○ No
   If not, how has your job changed? _____
2. What chemicals are you exposed to on your job? _____
3. How many hours a day are you exposed to chemicals? ____
4. Have you noticed any skin rash within the past year you feel was related to your work? ○ Yes ○ No
   If so, explain circumstances: _____
5. Have you noticed that any chemical makes you cough, be short of breath, or wheeze? ○ Yes ○ No
   If so, can you identify it? _____

Appendix D to §1910.1048
Medical Disease Questionnaire (non-mandatory)
(continued)

D. MISCELLANEOUS

1. Do you smoke? ○ Yes ○ No
   If so, how much and for how long? Pipe:_____ Cigars:_____ Cigarettes:_____
2. Do you drink alcohol in any form? ○ Yes ○ No
   If so, how much, how long and how often? _____
3. Do you wear glasses or contact lenses? ○ Yes ○ No
4. Do you get any physical exercise other than that required to do your job? ○ Yes ○ No
   If so, explain: _____
5. Do you have any hobbies or "side jobs" that require you to use chemicals, such as furniture stripping, sand blasting, insulation or manufacture of urethane foam, furniture, etc.? ○ Yes ○ No
   If so, please describe, giving type of business or hobby, chemicals used and length of exposures. _____

E. SYMPTOMS QUESTIONNAIRE

1. Do you ever have any shortness of breath? ○ Yes ○ No
   If Yes, do you have to rest after climbing several flights of stairs? ○ Yes ○ No
   If Yes, if you walk on the level with people your own age, do you walk slower than they do? ○ Yes ○ No
   If Yes, if you walk slower than a normal pace, do you have to limit the distance that you walk? ○ Yes ○ No
   If Yes, do you have to stop and rest while bathing or dressing? ○ Yes ○ No
2. Do you cough as much as three months out of the year? ○ Yes ○ No
   If Yes, have you had this cough for more than two years? ○ Yes ○ No
   If Yes, do you ever cough anything up from your chest? ○ Yes ○ No
3. Do you ever have a feeling of smothering, unable to take a deep breath, or tightness in your chest? ○ Yes ○ No
   If Yes, do you notice that this is on any particular day of the week? ○ Yes ○ No
   If Yes, what day of the week? ○ Mon ○ Tues ○ Wed ○ Thurs ○ Fri ○ Sat ○ Sun
   If Yes, do you notice that this occurs at any particular place? ○ Yes ○ No
   If Yes, do you notice that this is worse after you have returned to work after being off for several days? ○ Yes ○ No
4. Have you ever noticed any wheezing in your chest? ○ Yes ○ No
   If Yes, is this only with colds or other infections? ○ Yes ○ No
   Is this caused by exposure to any kind of dust or other material? ○ Yes ○ No
   If Yes, what kind? _____
5. Have you noticed any burning, tearing, or redness of your eyes when you are at work? ○ Yes ○ No
   If so, explain circumstances: _____
6. Have you noticed any sore or burning throat or itchy or burning nose when you are at work? ○ Yes ○ No
   If so, explain circumstances: _____
7. Have you noticed any stuffiness or dryness of your nose? ○ Yes ○ No
8. Do you ever have swelling of the eyelids or face? ○ Yes ○ No
9. Have you ever been jaundiced? ○ Yes ○ No
   If Yes, was this accompanied by any pain? ○ Yes ○ No
10. Have you ever had a tendency to bruise easily or bleed excessively? ○ Yes ○ No
11. Do you have frequent headaches that are not relieved by aspirin or Tylenol? ○ Yes ○ No
    If Yes, do they occur at any particular time of the day or week? ○ Yes ○ No
    If Yes, when do they occur? _____
12. Do you have frequent episodes of nervousness or irritability? ○ Yes ○ No
13. Do you tend to have trouble concentrating or remembering? ○ Yes ○ No
14. Do you ever feel dizzy, light-headed, excessively drowsy or like you have been drugged? ○ Yes ○ No
15. Does your vision ever become blurred? ○ Yes ○ No
16. Do you have numbness or tingling of the hands or feet or other parts of your body? ○ Yes ○ No
17. Have you ever had chronic weakness or fatigue? ○ Yes ○ No
18. Have you ever had any swelling of your feet or ankles to the point where you could not wear your shoes? ○ Yes ○ No
19. Are you bothered by heartburn or indigestion? ○ Yes ○ No
20. Do you ever have itching, dryness, or peeling and scaling of the hands? ○ Yes ○ No
21. Do you ever have a burning sensation in the hands, or reddening of the skin? ○ Yes ○ No
22. Do you ever have cracking or bleeding of the skin on your hands? ○ Yes ○ No
23. Are you under a physician's care? ○ Yes ○ No
    If Yes, for what are you being treated? _____
24. Do you have any physical complaints today? ○ Yes ○ No
    If Yes, explain: _____
25. Do you have other health conditions not covered by these questions? ○ Yes ○ No
    If Yes, explain: _____