**Appendix D §1910.1048 Nonmandatory Medical Disease Questionnaire**

## 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.___________________

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## 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 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 on any particular day of the week? [ ] YES [ ] NO

If yes, what day or the week? [ ] Mon [ ] Tues [ ] Wed [ ]Thrus [ ] 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:___________________