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

A. IDENTIFICATION

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

EMPLOYEE NAME: _____

SOCIAL SECURITY NUMBER: ___ — ___ — ___ 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: _____