14. Revise Appendix D of § 1910.1048 to read as follows:

APPENDIX D TO §1910.1048—NONMANDATORY MEDICAL DISEASE QUESTIONNAIRE

A. Identification

Plant Name: _____

Date: _____

Employee Name: _____

Job Title: _____

Birthdate: _____

Age: _____

Sex: _____

Height: _____

Weight: _____

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 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?

   _____
   _____

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 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?

   Yes__ No__

   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, and 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:

    _____
    _____