APPENDIX D TO § 1915.1001—MEDICAL QUESTIONNAIRES; MANDATORY

This mandatory appendix contains the medical questionnaires that must be administered to all employees who are exposed to asbestos, tremolite, anthophyllite, actinolite, or a combination of these minerals above the permissible exposure limit (0.1 f/cc), and who will therefore be included in their employer's medical surveillance program. Part 1 of the appendix contains the Initial Medical Questionnaire, which must be obtained for all new hires who will be covered by the medical surveillance requirements. Part 2 includes the abbreviated Periodical Medical Questionnaire, which must be administered to all employees who are provided periodic medical examinations under the medical surveillance provisions of the standard.

Part 1
INITIAL MEDICAL QUESTIONNAIRE

1. NAME____
2. CLOCK NUMBER_______________________________________
3. PRESENT OCCUPATION__________________________________
4. PLANT ____
5. ADDRESS____
6. ____
   (Zip Code)
7. TELEPHONE NUMBER___________________________________
8. INTERVIEWER____
9. DATE ____
10. Date of Birth ____
    Month Day Year
11. Place of Birth _______________________________________

12. Sex
    1. Male ___
    2. Female ___

13. What is your marital status?
    1. Single ___
    2. Married ___
    3. Widowed ___
    4. Separated/ Divorced ___

14. Race
    1. White ___
    2. Black ___
    3. Asian ___
    4. Hispanic ___
    5. Indian ___
    6. Other ___

15. What is the highest grade completed in school? ____________________
    (For example 12 years is completion of high school)

<u>OCCUPATIONAL HISTORY</u>

16A. Have you ever worked full time (30 hours per week or more) for 6 months or more? 1. Yes ___ 2. No ___

IF YES TO 16A:

B. Have you ever worked for a year or more in any dusty job? 1. Yes ___ 2. No ___ 3. Does Not Apply ___

Specify job/industry ________________________ Total Years Worked ___

Was dust exposure: 1. Mild ___ 2. Moderate ___ 3. Severe ___

C. Have you ever been exposed to gas or chemical fumes in your work? 1. Yes ___ 2. No ___

Specify job/industry ____________________ Total Years Worked ___

Was exposure: 1. Mild ____ 2. Moderate ___ 3. Severe ___

D. What has been your usual occupation or job -- the one you have worked at the longest?

1. Job occupation ____
2. Number of years employed in this occupation _____________________________
3. Position/job title ____
4. Business, field or industry ____

(Record on lines the years in which you have worked in any of these industries, e.g. 1960-1969)

Have you ever worked:	YES	NO
E. In a mine?	_____	_____
F. In a quarry?	_____	_____
G. In a foundry?	_____	_____
H. In a pottery?	_____	_____
I. In a cotton, flax or hemp mill?....	_____	_____
J. With asbestos?	_____	_____

17. <u>PAST MEDICAL HISTORY</u>	YES	NO
A. Do you consider yourself to be in good health?	_____	_____

If "NO" state reason ____

B. Have you any defect of vision? _____ _____

If "YES" state nature of defect ________________________________

C. Have you any hearing defect? _____ _____

If "YES" state nature of defect ________________________________

D. Are you suffering from or have you ever suffered from:	YES	NO
a. Epilepsy (or fits, seizures, convulsions)?	_____	_____
b. Rheumatic fever?	_____	_____
c. Kidney disease?	_____	_____
d. Bladder disease?	_____	_____
e. Diabetes?	_____	_____
f. Jaundice?	_____	_____

18. CHEST COLDS AND CHEST ILLNESSES

18A. If you get a cold, does it "usually" go to your chest? (Usually means more than 1/2 the time)
1. Yes ___ 2. No ___
3. Don't get colds ___

19A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
1. Yes ___ 2. No ___

IF YES TO 19A:

B. Did you produce phlegm with any of these chest illnesses?
1. Yes ___ 2. No ___
3. Does Not Apply ___

C. In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more?
Number of illnesses ___
No such illnesses ___

20. Did you have any lung trouble before the age of 16? — 1. Yes ___ 2. No ___

21. Have you ever had any of the following?

1A. Attacks of bronchitis? — 1. Yes ___ 2. No ___

IF YES TO 1A:

B. Was it confirmed by a doctor? — 1. Yes ___ 2. No ___ 3. Does Not Apply ___

C. At what age was your first attack? — Age in Years ___ Does Not Apply ___

2A. Pneumonia (include bronchopneumonia)? — 1. Yes ___ 2. No ___

IF YES TO 2A:

B. Was it confirmed by a doctor? — 1. Yes ___ 2. No ___ 3. Does Not Apply ___

C. At what age did you first have it? — Age in Years ___ Does Not Apply ___

3A. Hay Fever? — 1. Yes ___ 2. No ___

IF YES TO 3A:

B. Was it confirmed by a doctor? — 1. Yes ___ 2. No ___ 3. Does Not Apply ___

C. At what age did it start? — Age in Years ___ Does Not Apply ___

22A. Have you ever had chronic bronchitis? — 1. Yes ___ 2. No ___

IF YES TO 22A:

B. Do you still have it? — 1. Yes ___ 2. No ___ 3. Does Not Apply ___

C. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
3. Does Not Apply ___

D. At what age did it start? Age in Years ___
Does Not Apply ___

23A. Have you ever had emphysema? 1. Yes ___ 2. No ___

IF YES TO 23A:

B. Do you still have it? 1. Yes ___ 2. No ___
3. Does Not Apply ___

C. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
3. Does Not Apply ___

D. At what age did it start? Age in Years ___
Does Not Apply ___

24A. Have you ever had asthma? 1. Yes ___ 2. No ___

IF YES TO 24A:

B. Do you still have it? 1. Yes ___ 2. No ___
3. Does Not Apply ___

C. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
3. Does Not Apply ___

D. At what age did it start? Age in Years ___
Does Not Apply ___

E. If you no longer have it, at what age did it stop? Age stopped ___
Does Not Apply ___

25. Have you ever had:

A. Any other chest illness? 1. Yes ___ 2. No ___

If yes, please specify ____

B. Any chest operations? 1. Yes ___ 2. No ___

If yes, please specify ____

C. Any chest injuries? 1. Yes ___ 2. No ___

If yes, please specify ______________________________

26A. Has a doctor ever told you that you had heart trouble? 1. Yes ___ 2. No ___

IF YES TO 26A:

B. Have you ever had treatment for heart trouble in the past 10 years? 1. Yes ___ 2. No ___ 3. Does Not Apply ___

27A. Has a doctor told you that you had high blood pressure? 1. Yes ___ 2. No ___

IF YES TO 27A:

B. Have you had any treatment for high blood pressure (hypertension) in the past 10 years? 1. Yes ___ 2. No ___ 3. Does Not Apply ___

28. When did you last have your chest X-rayed? (Year) ___ ___ ___ ___

29. Where did you last have your chest X-rayed (if known)? ______________________________

What was the outcome? ______________________________

<u>FAMILY HISTORY</u>

30. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

	FATHER			MOTHER		
	1. Yes	2. No	3. Don't know	1. Yes	2. No	3. Don't know

A. Chronic Bronchitis? ___ ___ ___ ___ ___ ___

B. Emphysema? ___ ___ ___ ___ ___ ___

C. Asthma? ___ ___ ___ ___ ___ ___

D. Lung cancer? ___ ___ ___ ___ ___ ___

E. Other chest conditions? ___ ___ ___ ___ ___ ___

F. Is parent currently alive? ___ ___ ___ ___ ___ ___

G. Please Specify

___ Age if Living ___ Age if Living
___ Age at Death ___ Age at Death
___ Don't Know ___ Don't Know

H. Please specify cause of death _______________ ______________

COUGH

31A. Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.) (If no, skip to question 31C.) 1. Yes ___ 2. No ___

B. Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week? 1. Yes ___ 2. No ___

C. Do you usually cough at all on getting up or first thing in the morning? 1. Yes ___ 2. No ___

D. Do you usually cough at all during the rest of the day or at night? 1. Yes ___ 2. No ___

IF YES TO ANY OF ABOVE (31A, B, C, OR D), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO NEXT PAGE

E. Do you usually cough like this on most days for 3 consecutive months or more during the year? 1. Yes ___ 2. No ___ 3. Does not apply ___

F. For how many years have you had the cough? | Number of years ___
Does not apply ___

32A. Do you usually bring up phlegm from your chest?
Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.)
(If no, skip to 32C)
1. Yes ___ 2. No ___

B. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week?
1. Yes ___ 2. No ___

C. Do you usually bring up phlegm at all on getting up or first thing in the morning?
1. Yes ___ 2. No ___

D. Do you usually bring up phlegm at all on during the rest of the day or at night?
1. Yes ___ 2. No ___

IF YES TO ANY OF THE ABOVE (32A, B, C, OR D), ANSWER THE FOLLOWING:

IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO 33A

E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?
1. Yes ___ 2. No ___
3. Does not apply ___

F. For how many years have you had trouble with phlegm?
Number of years ___
Does not apply ___

<u>EPISODES OF COUGH AND PHLEGM</u>

33A. Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year?
*(For persons who usually have cough and/or phlegm)
1. Yes ___ 2. No ___

IF YES TO 33A

B. For how long have you had at least 1 such episode per year?
Number of years ___
Does not apply ___

WHEEZING

34A. Does your chest ever sound wheezy or whistling

1. When you have a cold? 1. Yes ___ 2. No ___

2. Occasionally apart from colds? 1. Yes ___ 2. No ___

3. Most days or nights? 1. Yes ___ 2. No ___

B. For how many years has this been present?
Number of years ___
Does not apply ___

35A. Have you ever had an attack of wheezing that has made you feel short of breath? 1. Yes ___ 2. No ___

IF YES TO 35A

B. How old were you when you had your first such attack?
Age in years ___
Does not apply ___

C. Have you had 2 or more such episodes?
1. Yes ___ 2. No ___
3. Does not apply ___

D. Have you ever required medicine or treatment for the(se) attack(s)?
1. Yes ___ 2. No ___
3. Does not apply ___

BREATHLESSNESS

36. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 38A.
Nature of condition(s)
____
____

37A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill? 1. Yes ___ 2. No ___

IF YES TO 37A

B. Do you have to walk slower 1. Yes ___ 2. No ___

than people of your age on the level because of breathlessness? | 3. Does not apply ___

Question	Response
C. Do you ever have to stop for breath when walking at your own pace on the level?	1. Yes ___ 2. No ___ 3. Does not apply ___
D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?	1. Yes ___ 2. No ___ 3. Does not apply ___
E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs?	1. Yes ___ 2. No ___ 3. Does not apply ___

<u>TOBACCO SMOKING</u>

Question	Response
38A. Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year.)	1. Yes ___ 2. No ___

IF YES TO 38A

Question	Response
B. Do you now smoke cigarettes (as of one month ago)	1. Yes ___ 2. No ___ 3. Does not apply ___
C. How old were you when you first started regular cigarette smoking?	Age in years ___ Does not apply ___
D. If you have stopped smoking cigarettes completely, how old were you when you stopped?	Age stopped ___ Check if still smoking ___ Does not apply ___
E. How many cigarettes do you smoke per day now?	Cigarettes per day ___ Does not apply ___

F. On the average of the entire time you smoked, how many cigarettes did you smoke per day?

Cigarettes per day ___
Does not apply ___

G. Do or did you inhale the cigarette smoke?

1. Does not apply ___
2. Not at all ___
3. Slightly ___
4. Moderately ___
5. Deeply ___

39A. Have you ever smoked a pipe regularly?
(Yes means more than 12 oz. of tobacco in a lifetime.)

1. Yes ___ 2. No ___

IF YES TO 39A:
FOR PERSONS WHO HAVE EVER SMOKED A PIPE

B. 1. How old were you when you started to smoke a pipe regularly?

Age ___

2. If you have stopped smoking a pipe completely, how old were you when you stopped?

Age stopped ___
Check if still smoking pipe ___
Does not apply ___

C. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week?

___ oz. per week (a standard pouch of tobacco contains 1 1/2 oz.)

___ Does not apply

D. How much pipe tobacco are you smoking now?

oz. per week ___
Not currently smoking a pipe ___

E. Do you or did you inhale the pipe smoke?

1. Never smoked ___
2. Not at all ___
3. Slightly ___
4. Moderately ___
5. Deeply ___

40A. Have you ever smoked cigars regularly?

1. Yes ___ 2. No ___

(Yes means more than 1 cigar a week for a year)

IF YES TO 40A

FOR PERSONS WHO HAVE EVER SMOKED A PIPE

B. 1. How old were you when you started smoking cigars regularly?	Age ___
2. If you have stopped smoking cigars completely, how old were you when you stopped smoking cigars?	Age stopped ___ Check if still ___ Does not apply ___
C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week?	Cigars per week ___ Does not apply ___
D. How many cigars are you smoking per week now?	Cigars per week ___ Check if not smoking cigars currently ___
E. Do or did you inhale the cigar smoke?	1. Never smoked ___ 2. Not at all ___ 3. Slightly ___ 4. Moderately ___ 5. Deeply ___

Signature ______________________________ Date __________________________

Part 2
PERIODIC MEDICAL QUESTIONNAIRE

1. NAME ____
2. CLOCK NUMBER ___ ___ ___ ___ ___ ___ ___
3. PRESENT OCCUPATION ____
4. PLANT ____
5. ADDRESS ____
6. ____

(Zip Code)

7. TELEPHONE NUMBER ____

8. INTERVIEWER ____

9. DATE ____

10. What is your marital status?
1. Single ___
2. Married ___
3. Widowed ___
4. Separated/ Divorced ___

11. <u>OCCUPATIONAL HISTORY</u>

11A. In the past year, did you work full time (30 hours per week or more) for 6 months or more? 1. Yes ___ 2. No ___

IF YES TO 11A:

11B. In the past year, did you work in a dusty job? 1. Yes ___ 2. No ___ 3. Does not Apply ___

11C. Was dust exposure: 1. Mild ___ 2. Moderate ___ 3. Severe ___

11D. In the past year, were you exposed to gas or chemical fumes in your work? 1. Yes ___ 2. No ___

11E. Was exposure: 1. Mild ___ 2. Moderate ___ 3. Severe ___

11F. In the past year, what was your:
1. Job/occupation? ________________________
2. Position/job title? ________________________

12. <u>RECENT MEDICAL HISTORY</u>

12A. Do you consider yourself to be in good health? Yes ___ No ___

If NO, state reason ____

12B. In the past year, have you developed:

	Yes	No
Epilepsy?	___	___
Rheumatic fever?	___	___
Kidney disease?	___	___
Bladder disease?	___	___
Diabetes?	___	___
Jaundice?	___	___
Cancer?	___	___

13. CHEST COLDS AND CHEST ILLNESSES

13A. If you get a cold, does it "usually" go to your chest? (usually means more than 1/2 the time)
1. Yes ___ 2. No ___
3. Don't get colds ___

14A. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
1. Yes ___ 2. No ___
3. Does Not Apply ___

IF YES TO 14A:

14B. Did you produce phlegm with any of these chest illnesses?
1. Yes ___ 2. No ___
3. Does Not Apply ___

14C. In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more?
Number of illnesses ___
No such illnesses ___

15. RESPIRATORY SYSTEM

In the past year have you had:

	Yes or No	Further Comment on Positive Answers
Asthma	______	
Bronchitis	______	
Hay Fever	______	
Other Allergies	______	

	Yes or No	Further Comment on Positive Answers
Pneumonia	______	
Tuberculosis	______	
Chest Surgery	______	
Other Lung Problems	______	
Heart Disease	______	

Do you have:

	Yes or No	Further Comment on Positive Answers
Frequent colds	______	
Chronic cough	______	
Shortness of breath when walking or climbing one flight		

or stairs _____

Do you:
Wheeze _____
Cough up phlegm _____
Smoke cigarettes _____ Packs per day ____ How many years ___

Date _________________ Signature ____________________________________