

# Asbestos in Shipyards

## § 1915.1001

### ~~APPENDIX C TO § 1915.1001—QUALITATIVE AND QUANTITATIVE FIT TESTING PROCEDURES. MANDATORY~~

~~Employers must perform fit testing in accordance with the fit testing requirements of 29 CFR 1910.134(f) and the qualitative and quantitative fit-testing protocols and procedures specified in Appendix A of 29 CFR 1910.134.~~

### ~~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~~

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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.



17A. Have you ever worked full time (30 hours 1. Yes \_ 2. No\_\_  
per week or more) for 6 months or more?

IF YES TO 17A:

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

Specify job/industry \_\_\_\_\_ Total Years  
Worked \_\_

Was dust exposure: 1. Mild \_\_ 2. Moderate \_\_  
3. Severe \_\_

C. Have you even been exposed to gas or 1. Yes \_\_ 2. No \_\_  
chemical fumes in your work?

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?..... [ ] [ ]

18. PAST MEDICAL HISTORY

- 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)? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Rheumatic fever?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Kidney disease?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Bladder disease?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Diabetes?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Jaundice?                                  | <input type="checkbox"/> | <input type="checkbox"/> |

19. CHEST COLDS AND CHEST ILLNESSES

- 19A. 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\_\_
- 20A. 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 20A:
- 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 \_\_\_\_

21. Did you have any lung trouble before the age of 16?  
 1. Yes\_\_ 2. No\_\_
22. 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 \_
- 23A. Have you ever had chronic bronchitis? 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 emphysema? 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 \_
- 25A. Have you ever had asthma? 1. Yes\_\_ 2. No\_\_  
 IF YES TO 25A:

- 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 \_
26. 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 \_\_\_\_\_
- 27A. Has a doctor ever told you that you had heart trouble?  
1. Yes\_\_ 2. No\_\_
- IF YES TO 27A:
- B. Have you ever had treatment for heart trouble in the past  
10 years? 1. Yes\_\_ 2. No\_\_  
3. Does Not Apply \_
- 28A. Has a doctor ever told you that you had high blood  
pressure? 1. Yes\_\_ 2. No\_\_
- IF YES TO 28A:
- B. Have you had any treatment for high blood pressure  
(hypertension in the past 10 years)? 1. Yes\_\_ 2. No\_\_  
3. Does Not Apply \_
29. When did you last have your chest X-rayed?  
(Year) \_ \_ \_ \_
30. Where did you last have your chest X-rayed (if known)?  
\_\_\_\_\_

What was the outcome? \_\_\_\_\_

FAMILY HISTORY

31. 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.
Chronic bronchitis?	___	___	___	___	___	___
Emphysema?	___	___	___	___	___	___
Asthma?	___	___	___	___	___	___
Lung cancer?	___	___	___	___	___	___
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

32A. Do you usually have a cough? (Count cough with first smoke or on first going out of doors. Exclude clearing of throat.) [If no, skip to question 32C.]  
 1. Yes \_\_\_ 2. No \_\_\_

32B. Do you usually cough as much as 4 to 6 times a day 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 (32A, 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 \_\_\_
- 33A. 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 33C)  
 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 during the rest of the day or at night?  
 1. Yes \_\_\_ 2. No \_\_\_

IF YES TO ANY OF THE ABOVE (33A, B, C, or D), ANSWER THE FOLLOWING:  
 IF NO TO ALL, CHECK DOES NOT APPLY AND SKIP TO 34A.

- 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 \_\_\_

EPISODES OF COUGH AND PHLEGM

- 34A. 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 34A
- B. For how long have you had at least 1 such episode per year?



Number of years \_\_\_\_\_  
 Does not apply \_\_\_\_\_

WHEEZING

- 35A. 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 \_\_\_

IF YES TO 1, 2, or 3 in 35A

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

- 36A. Have you ever had an attack of wheezing that has made you feel short of breath?

1. Yes \_\_\_ 2. No \_\_\_

IF YES TO 36A

- 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 medicine for the(se) attack(s)?
- 1. Yes \_\_\_ 2. No \_\_\_
  - 3. Does not apply \_\_\_\_\_

BREATHLESSNESS

37. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 39A.

Nature of condition(s) \_\_\_\_\_  
 \_\_\_\_\_

- 38A. 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 38A

- B. Do you have to walk slower than people of your age on the level because of breathlessness?

1. Yes \_\_\_ 2. No \_\_\_

3. Does not apply —
- 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 —

TOBACCO SMOKING

- 39A. 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 39A
- B. Do you now smoke cigarettes (as of one month age)?
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 —
- 5 G. Do or did you inhale the cigarette smoke?
1. Does not apply —

- 2. Not at all
- 3. Slightly
- 4. Moderately
- 5. Deeply

40A. 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 40A:

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

41A. Have you ever smoked cigars regularly?  
 1. Yes  2. No   
 (Yes means more than 1 cigar a week for a  
 year)

IF YES TO 41A

FOR PERSONS WHO HAVE EVER SMOKED CIGARS

- B. 1. How old were you when you started  
 smoking cigars regularly? Age



Part 2  
 PERIODIC MEDICAL QUESTIONNAIRE

Removed #2  
 and renumbered →

1. NAME \_\_\_\_\_
- ~~2.~~ SOCIAL SECURITY # \_\_\_\_\_
3. CLOCK NUMBER \_\_\_\_\_
4. PRESENT OCCUPATION \_\_\_\_\_
5. PLANT \_\_\_\_\_
6. ADDRESS \_\_\_\_\_
7. \_\_\_\_\_  
 (Zip Code)
8. TELEPHONE NUMBER \_\_\_\_\_
9. INTERVIEWER \_\_\_\_\_
10. DATE \_\_\_\_\_
11. What is your marital status?
 

1. Single	___	4. Separated/
2. Married	___	Divorced
3. Widowed	___	
12. OCCUPATIONAL HISTORY
- 12A. In the past year, did you work full time (30 hours per week or more) for 6 months or more?
 

1. Yes	___	2. No	___
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IF YES TO 12A:
- 12B. In the past year, did you work in a dusty job?
 

1. Yes	___	2. No	___
3. Does Not Apply	___		
- 12C. Was dust exposure:
 

1. Mild	___	2. Moderate	___
3. Severe	___		
- 12D. In the past year, were you exposed to gas or chemical fumes in your work?
 

1. Yes	___	2. No	___
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- 12E. Was exposure: 1. Mild  2. Moderate   
3. Severe
- 12F. In the past year, what was your: 1. Job/occupation? \_\_\_\_\_  
2. Position/job title? \_\_\_\_\_
13. RECENT MEDICAL HISTORY
- 13A. Do you consider yourself to be in good health? Yes  No   
If NO, state reason \_\_\_\_\_
- 13B. In the past year, have you developed:
- |                  | <u>Yes</u> | <u>No</u> |
|------------------|------------|-----------|
| Epilepsy?        | ___        | ___       |
| Rheumatic fever? | ___        | ___       |
| Kidney disease?  | ___        | ___       |
| Bladder disease? | ___        | ___       |
| Diabetes?        | ___        | ___       |
| Jaundice?        | ___        | ___       |
| Cancer?          | ___        | ___       |
14. CHEST COLDS AND CHEST ILLNESSES
- 14A. 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
- 15A. 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 15A:
- 15B. Did you produce phlegm with any of these chest illnesses?  
1. Yes  2. No   
3. Does Not Apply
- 15C. 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

16. RESPIRATORY SYSTEM

In the past year have you had:

	<u>Yes or No</u>	<u>Further Comment on Positive Answers</u>
Asthma	_____	
Bronchitis	_____	
Hay Fever	_____	
Other Allergies	_____	

	<u>Yes or No</u>	<u>Further Comment on Positive Answers</u>
Pneumonia	_____	
Tuberculosis	_____	
Chest Surgery	_____	
Other Lung Problems	_____	
Heart Disease	_____	

Do you have:

	<u>Yes or No</u>	<u>Further Comment on Positive Answers</u>
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 \_\_\_\_\_