

APPENDIX D TO § 1926.1101—MEDICAL QUESTIONNAIRES; MANDATORY

This mandatory appendix contains the medical questionnaires that must be administered to all employees who are exposed to asbestos above permissible exposure limit, 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 ___ 4. Separated/
2. Married ___ Divorced ___
3. Widowed ___
14. Race
1. White ___ 4. Hispanic ___
2. Black ___ 5. Indian ___
3. Asian ___ 6. Other ___
15. What is the highest grade completed in school? _____
(For example 12 years is completion of high school)

OCCUPATIONAL HISTORY

- 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
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a. Epilepsy (or fits, seizures, convulsions)?	_____	_____
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b. Rheumatic fever?	_____	_____
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c. Kidney disease?	_____	_____
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d. Bladder disease?	_____	_____
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e. Diabetes?	_____	_____
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f. Jaundice?	_____	_____
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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 ____
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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 ____
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IF YES TO 19A:

B. Did you produce phlegm with any of these chest illnesses?	1. Yes ____	2. No ____	3. Does Not Apply ____
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C. In the last 3 years, how many such illnesses with (increased) phlegm did you	Number of illnesses ____	No such illnesses ____
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have which lasted a week or more?

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? _____

FAMILY HISTORY

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

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? 1. Yes ____ 2. No ____
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)

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 ____

EPISODES OF COUGH AND PHLEGM

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

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 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

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

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? 1. Yes ____ 2. No ____
(Yes means more than 12 oz. of tobacco in a lifetime.)

**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 _____

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:

	<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 _____