**Appendix F to §1910.1051—Medical Questionnaires (Non-Mandatory)**)

**1,3-Butadiene (BD) Initial Health Questionnaire**

DIRECTIONS:

You have been asked to answer the questions on this form because you work with BD (butadiene). These questions are about your work, medical history, and health concerns. Please do your best to answer all of the questions. If you need help, please tell the doctor or health care professional who reviews this form.

This form is a confidential medical record. Only information directly related to your health and safety on the job may be given to your employer. Personal health information will not be given to anyone without your consent.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

Last First MI

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor's Phone No.: ( ) \_\_\_\_-\_\_\_\_\_

**Work History**

1. Please list all jobs you have had in the past, starting with the job you have now and moving back in time to your first job. (For more space, write on the back of this page.)

|  |  |  |  |
| --- | --- | --- | --- |
| **Main Job Duty** | **Years** | **Company Name City, State** | **Chemicals** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| 7. |  |  |  |
| 8. |  |  |  |

1. Please describe what you do during a typical work day. Be sure to tell about you work with BD

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please check any of these chemicals that you work with now or have worked with in the past:

benzene \_\_\_\_

glues \_\_\_\_

toluene \_\_\_\_

inks, dyes \_\_\_\_

other solvents, grease cutters *\_\_\_\_*

insecticides (like DDT, lindane, etc.) \_\_\_\_

paints, varnishes, thinners, strippers \_\_\_\_

dusts \_\_\_\_

carbon tetrachloride ("carbon tet") \_\_\_\_

arsine \_\_\_\_

carbon disulfide \_\_\_\_

lead \_\_\_\_

cement \_\_\_\_

petroleum products \_\_\_\_

nitrites \_\_\_\_

1. Please check the protective clothing or equipment you use at the job you have now:

gloves \_\_\_\_

coveralls \_\_\_\_

respirator \_\_\_\_

dust mask \_\_\_\_

safety glasses, goggles \_\_\_\_

Please circle your answer of yes or no.

1. Does your protective clothing or equipment fit you properly?

yes no

1. Have you ever made changes in your protective clothing or equipment to make it fit better?

yes no

1. Have you been exposed to BD when you were not wearing protective clothing or equipment?

yes no

1. Where do you eat, drink and/or smoke when you are at work?

(Please check all that apply.)

Cafeteria/restaurant/snack bar \_\_\_\_

Break room/employee lounge \_\_\_\_

Smoking lounge \_\_\_\_

At my work station \_\_\_\_

Please circle your answer.

1. Have you been exposed to radiation (like x-rays or nuclear material) at the job you have now or at past jobs?

yes no

1. Do you have any hobbies that expose you to dusts or chemicals (including paints, glues, etc.)?

yes no

1. Do you have any second or side jobs?

yes no

If yes, what are your duties there? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Were you in the military?

yes no

If yes, what did you do in the military? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family Health History**

1. In the FAMILY MEMBER column, across from the disease name, write which family member, if any, had the disease.

|  |  |
| --- | --- |
| **Disease** | **Family Member** |
| Cancer |  |
| Lymphoma |  |
| Sickle Cell Disease or Trait |  |
| Immune Disease |  |
| Leukemia |  |
| Anemia |  |

2. Please fill in the following information about family health:

|  |  |  |  |
| --- | --- | --- | --- |
| **RELATIVE** | **ALIVE?** | **AGE AT DEATH?** | **CAUSE OF DEATH?** |
| Father |  |  |  |
| Mother |  |  |  |
| Brother/Sister |  |  |  |
| Brother/Sister |  |  |  |
| Brother/Sister |  |  |  |

**PERSONAL HEALTH HISTORY**

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_ Height \_\_\_\_\_\_ Weight \_\_\_\_\_

Please circle your answer.

1. Do you smoke any tobacco products?

yes no

1. Have you ever had any kind of surgery or operation?

yes no

If yes, what type of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Have you ever been in the hospital for any other reasons?

yes no

If yes, please describe the reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Do you have any on-going or current medical problems or conditions?

yes no

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Do you now have or have you ever had any of the following?

Please check all that apply to you.

unexplained fever \_\_\_\_

anemia ("low blood") \_\_\_\_

HIV/AIDS \_\_\_\_

weakness \_\_\_\_

sickle cell \_\_\_\_

miscarriage \_\_\_\_

skin rash \_\_\_\_

bloody stools \_\_\_\_

leukemia/lymphoma \_\_\_\_

neck mass/swelling \_\_\_\_

wheezing \_\_\_\_

yellowing of skin \_\_\_\_

bruising easily \_\_\_\_

lupus \_\_\_\_

weight loss \_\_\_\_

kidney problems \_\_\_\_

enlarged lymph nodes \_\_\_\_

liver disease \_\_\_\_

cancer \_\_\_\_

infertility \_\_\_\_

drinking problems \_\_\_\_

thyroid problems \_\_\_\_

night sweats \_\_\_\_

chest pain \_\_\_\_

still birth \_\_\_\_

eye redness \_\_\_\_

lumps you can feel \_\_\_\_

child with birth defect \_\_\_\_

autoimmune disease \_\_\_\_

overly tired \_\_\_\_

lung problems \_\_\_\_

rheumatoid arthritis \_\_\_\_

mononucleosis("mono") \_\_\_\_

nagging cough \_\_\_\_

Please circle your answer.

1. Do you have any symptoms or health problems that you think may be related to your work with BD?

yes no

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Have any of your co-workers had similar symptoms or problems?

yes no don't know

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Do you notice any irritation of your eyes, nose, throat, lungs or skin when working with BD?

yes no

1. Do you notice any blurred vision, coughing, drowsiness, nausea, or headache when

working with BD?

yes no

1. Do you take any medications (including birth control or over-the-counter)?

yes no

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Are you allergic to any medication, food, or chemicals?

yes no

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Do you have any health conditions not covered by this questionnaire that you think are affected by your work with BD?

yes no

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you understand all the questions?

yes no

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature