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.			

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

_____

_____

3. _____

_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 ____

4. 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.

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

   yes no

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

   yes no

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

   yes no

8. 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.

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

   yes no

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

    yes no

11. Do you have any second or side jobs?

    yes no

If yes, what are your duties there? _____

_____

_____

_____

12. Were you in the military?

    yes no

If yes, what did you do in the military? _____

_____

_____

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

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

yes no

If yes, what type of surgery: _____

_____

_____

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

yes no

If yes, please describe the reason: _____

_____

_____

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

yes no

If yes, please describe: _____

_____

_____

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

Please check all that apply to you.

unexplained fever	____	liver disease	____
anemia ("low blood")	____	cancer	____
HIV/AIDS	____	infertility	____
weakness	____	drinking problems	____
sickle cell	____	thyroid problems	____
miscarriage	____	night sweats	____
skin rash	____	chest pain	____
bloody stools	____	still birth	____
leukemia/lymphoma	____	eye redness	____
neck mass/swelling	____	lumps you can feel	____
wheezing	____	child with birth defect	____
yellowing of skin	____	autoimmune disease	____
bruising easily	____	overly tired	____
lupus	____	lung problems	____
weight loss	____	rheumatoid arthritis	____
kidney problems	____	mononucleosis("mono")	____
enlarged lymph nodes	____	nagging cough	____

Please circle your answer.

6. 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: _____

_____

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

yes no don't know

If yes, please describe: _____

_____

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

yes no

9. Do you notice any blurred vision, coughing, drowsiness, nausea, or headache when working with BD?

yes no

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

yes no

If yes, please list: _____

_____

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

yes no

If yes, please list: _____

_____

12. 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: _____

_____

13. Did you understand all the questions?

yes no

_____

Signature