APPENDIX D TO §1910.1001—MEDICAL QUESTIONNAIRES; MANDATORY

This mandatory appendix contains the medical questionnaires that must be administered to all employees who are exposed to asbestos above the 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

PAPERWORK REDUCTION ACT STATEMENT

Under the asbestos in general industry standard, this medical questionnaire must be administered to all employees who are exposed to asbestos above the permissible exposure limit, and who will therefore be included in their employer's medical surveillance program. (29 CFR 1910.1001(l)(2)(ii)). According to the Paperwork Reduction Act, an Agency may not conduct or sponsor, and no persons are required to respond to, a collection of information unless such collection displays a valid OMB control number. Use of this questionnaire is mandatory. The questionnaire assists both physicians and employers to ensure that the physician obtains compliant employee medical documentation. OSHA estimates employer burden for the completion of this collection of information is 2 hours and 20 minutes (2.33 hours). This estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and, completing and reviewing the collection of information. The time estimate includes employer time for compliance with the underlying collections of information in 29 CFR 1910.1001(l), including employee time for completion of the questionnaire and medical examination, providing information to the physician, and maintaining employee medical records. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to OSHAPRA@dol.gov or to OSHA's Directorate of Standards and Guidance, Department of Labor, Room N-3718, 200 Constitution Ave., NW, Washington, DC; 20210; Attn: Paperwork Reduction Act Comment. (This address is for comments regarding this form only; **DO NOT SEND ANY COMPLETED SAMPLE FORM TO THIS OFFICE**.)

OMB Approval# 1218-0133; Expires: 00-00-0000

Part 1
INITIAL MEDICAL QUESTIONNAIRE

1. NAME _____

2. SOCIAL SECURITY # ___ ___ ___ ___ ___ ___ ___ ___ ___
(1 2 3 4 5 6 7 8 9)

3. CLOCK NUMBER ___ ___ ___ ___ ___ ___
(10 11 12 13 14 15)

4. PRESENT OCCUPATION _____

5. PLANT _____

6. ADDRESS _____

7. _____
(Zip Code)

8. TELEPHONE NUMBER _____

9. INTERVIEWER _____

10. DATE _____ ___ ___ ___ ___ ___ ___
(16 17 18 19 20 21)

11. Date of Birth _____ ___ ___ ___ ___ ___ ___
Month Day Year (22 23 24 25 26 27)

12. Place of Birth _____

13. Sex
1. Male ___
2. Female ___

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

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

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

OCCUPATIONAL HISTORY

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

IF YES TO 17A:

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 even 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?.....	[__]	[__]

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:

a. Epilepsy (or fits, seizures, convulsions)?	[__]	[__]
b. Rheumatic fever?	[__]	[__]
c. Kidney disease?	[__]	[__]
d. Bladder disease?	[__]	[__]
e. Diabetes?	[__]	[__]
f. Jaundice?	[__]	[__]

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) $\frac{}{25}$ $\frac{}{26}$ $\frac{}{27}$ $\frac{}{28}$

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

H. Please specify cause of death

_____ _____

COUGH

32A. 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 32C.] 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 (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 treatment 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 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 __

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? (Yes means more than 1 cigar a week for a year) — 1. Yes __ 2. No __

IF YES TO 41A
FOR PERSONS WHO HAVE EVER SMOKED CIGARS

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. — Age stopped __ / Check if still smoking cigars __ / 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. SOCIAL SECURITY # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7 8 9

3. CLOCK NUMBER ___ ___ ___ ___ ___ ___ ___
10 11 12 13 14 15

4. PRESENT OCCUPATION _____

5. PLANT _____

6. ADDRESS _____

7. _____
(Zip Code)

8. TELEPHONE NUMBER _____

9. INTERVIEWER _____

10. DATE _____ ___ ___ ___ ___ ___ ___ ___
16 17 18 19 20 21

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

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 ___

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:

	Yes	No
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:

	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 _____