APPENDIX D TO §1910.1048—NONMANDATORY MEDICAL DISEASE QUESTIONNAIRE

PAPERWORK REDUCTION ACT STATEMENT

Under the formaldehyde standard, this nonmandatory medical disease questionnaire may be administered to employees who are exposed to formaldehyde at or above the action level or above the STEL and who will therefore be included in their employer's medical surveillance program. (29 CFR 1910.1048(l)(3)(i)). 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 optional. 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 70 minutes (1.16 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 29 CFR 1910.1048(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# 1218-0145; Expires: 00-00-0000

A. Identification

Plant Name _____

Date _____

Employee Name _____

S.S. # _____

Job Title _____

Birthdate: _____

Age: _____

Sex: _____

Height: _____

Weight: _____

B. Medical History

1. Have you ever been in the hospital as a patient?

Yes ☐ No ☐

If yes, what kind of problem were you having? _____

_____

2. Have you ever had any kind of operation?

Yes ☐ No ☐

If yes, what kind? _____

_____

3. Do you take any kind of medicine regularly?

Yes ☐ No ☐

If yes, what kind? _____

_____

4. Are you allergic to any drugs, foods, or chemicals?

Yes ☐ No ☐

If yes, what kind of allergy is it? _____

_____

What causes the allergy? _____

5. Have you ever been told that you have asthma, hayfever, or sinusitis?

Yes ☐ No ☐

6. Have you ever been told that you have emphysema, bronchitis, or any other respiratory problems?

Yes ☐ No ☐

7. Have you ever been told you had hepatitis?

Yes ☐ No ☐

8. Have you ever been told that you had cirrhosis?

Yes ☐ No ☐

9. Have you ever been told that you had cancer?

Yes ☐ No ☐

10. Have you ever had arthritis or joint pain?

Yes ☐ No ☐

11.. Have you ever been told that you had high blood pressure? Yes ☐ No ☐

12. . Have you ever had a heart attack or heart trouble?

Yes ☐ No ☐

B-1. Medical History Update

1. Have you been in the hospital as a patient any time within the past year?

Yes ☐ No ☐

If so, for what condition? _____

_____

2. Have you been under the care of a physician during the past year?

Yes ☐ No ☐

If so, for what condition? _____

_____

3. Is there any change in your breathing since last year?

Yes ☐ No ☐

Better? _____

Worse? _____

No change? _____

If change, do you know why? _____

_____

4. Is your general health different this year from last year?

Yes ☐ No ☐

If different, in what way? _____

_____

5. Have you in the past year or are you now taking any medication on a regular basis?

Yes ☐ No ☐

Name Rx _____

Condition being treated _____

C. Occupational History

1. How long have you worked for your present employer?

_____

2. What jobs have you held with this employer? Include job title and length of time in each job.

_____

_____

_____

_____

3. In each of these jobs, how many hours a day were you exposed to chemicals?

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4. What chemicals have you worked with most of the time?

5. Have you ever noticed any type of skin rash you feel was related to your work?
Yes ☐ No ☐

6. Have you ever noticed that any kind of chemical makes you cough?
Yes ☐ No ☐

Wheeze?
Yes ☐ No ☐

Become short of breath or cause your chest to become tight?
Yes ☐ No ☐

7. Are you exposed to any dust or chemicals at home?
Yes ☐ No ☐

If yes, explain:

8. In other jobs, have you ever had exposure to:

Wood dust?

Yes ☐ No ☐

Nickel or chromium?
Yes ☐ No ☐

Silica (foundry, sand blasting)?
Yes ☐ No ☐

Arsenic or asbestos?
Yes ☐ No ☐

Organic solvents?
Yes ☐ No ☐

Urethane foams?

Yes ☐ No ☐

C-1. Occupational History Update

1. Are you working on the same job this year as you were last year?
Yes ☐ No ☐

If not, how has your job changed?

2. What chemicals are you exposed to on your job?

3. How many hours a day are you exposed to chemicals?

4. Have you noticed any skin rash within the past year you feel was related to your work?
Yes ☐ No ☐

If so, explain circumstances:

5. Have you noticed that any chemical makes you cough, be short of breath, or wheeze?
Yes ☐ No ☐

D. Miscellaneous

1. Do you smoke?

Yes ☐ No ☐

If so, how much and for how long? _____

_____

Pipe _____

Cigars _____

Cigarettes _____

2. Do you drink alcohol in any form?

Yes ☐ No ☐

If so, how much, how long, and how often? _____

_____

3. Do you wear glasses or contact lenses?

Yes ☐ No ☐

4. Do you get any physical exercise other than that required to do your job?

Yes ☐ No ☐

If so, explain: _____

_____

5. Do you have any hobbies or "side jobs" that require you to use chemicals, such as furniture stripping, sand blasting, insulation or manufacture of urethane foam, furniture, etc?

Yes ☐ No ☐

If so, please describe, giving type of business or hobby, chemicals used and length of exposures.

_____

E. Symptoms Questionnaire

1. Do you ever have any shortness of breath?

Yes ☐ No ☐

If yes, do you have to rest after climbing several flights of stairs?

Yes ☐ No ☐

If yes, if you walk on the level with people your own age, do you walk slower than they do?

Yes ☐ No ☐

If yes, if you walk slower than a normal pace, do you have to limit the distance that you walk?

Yes ☐ No ☐

If yes, do you have to stop and rest while bathing or dressing?

Yes ☐ No ☐

2. Do you cough as much as three months out of the year?

Yes ☐ No ☐

If yes, have you had this cough for more than two years?

Yes ☐ No ☐

If yes, do you ever cough anything up from chest?

Yes ☐ No ☐

3. Do you ever have a feeling of smothering, unable to take a deep breath, or tightness in your chest?
Yes ☐ No ☐

If yes, do you notice that this on any particular day of the week?
Yes ☐ No ☐

If yes, what day or the week?
Yes ☐ No ☐

If yes, do you notice that this occurs at any particular place?
Yes ☐ No ☐

If yes, do you notice that this is worse after you have returned to work after being off for several days?
Yes ☐ No ☐

4. Have you ever noticed any wheezing in your chest?
Yes ☐ No ☐

If yes, is this only with colds or other infections?
Yes ☐ No ☐

Is this caused by exposure to any kind of dust or other material?
Yes ☐ No ☐

If yes, what kind? _____

5. Have you noticed any burning, tearing, or redness of your eyes when you are at work?
Yes ☐ No ☐

If so, explain circumstances: _____

_____

6. Have you noticed any sore or burning throat or itchy or burning nose when you are at work?
Yes ☐ No ☐

If so, explain circumstances: _____

_____

7. Have you noticed any stuffiness or dryness of your nose?
Yes ☐ No ☐

8. Do you ever have swelling of the eyelids or face?
Yes ☐ No ☐

9. Have you ever been jaundiced?
Yes ☐ No ☐

If yes, was this accompanied by any pain?
Yes ☐ No ☐

10. Have you ever had a tendency to bruise easily or bleed excessively?
Yes ☐ No ☐

11.. Do you have frequent headaches that are not relieved by aspirin or tylenol? Yes ☐ No ☐

If yes, do they occur at any particular time of the day or week?
Yes ☐ No ☐

If yes, when do they occur? _____

_____

12.. Do you have frequent episodes of nervousness or irritability? Yes ☐ No ☐

13.. Do you tend to have trouble concentrating or remembering? Yes ☐ No ☐

14. Do you ever feel dizzy, light-headed, excessively drowsy or like you have been drugged? Yes ☐ No ☐

15.. Does your vision ever become blurred? Yes ☐ No ☐

16.. Do you have numbness or tingling of the hands or feet or other parts of your body? Yes ☐ No ☐

17.. Have you ever had chronic weakness or fatigue? Yes ☐ No ☐

18.. Have you ever had any swelling of your feet or ankles to the point where you could not wear your shoes? Yes ☐ No ☐

19. Are you bothered by heartburn or indigestion? Yes ☐ No ☐

20.. Do you ever have itching, dryness, or peeling and scaling of the hands? Yes ☐ No ☐

21.. Do you ever have a burning sensation in the hands, or reddening of the skin? Yes ☐ No ☐

22.. Do you ever have cracking or bleeding of the skin on your hands? Yes ☐ No ☐

23. Are you under a physician's care? Yes ☐ No ☐

If yes, for what are you being treated? _____

_____

24.. Do you have any physical complaints today? Yes ☐ No ☐

If yes, explain? _____

_____

25.. Do you have other health conditions not covered by these questions? Yes ☐ No ☐

If yes, explain: _____

_____