

SIPS - NI mark-up  
9/24/18

Occupational Safety and Health Admin., Labor

§ 1910.1051

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: \_\_\_\_\_ SSN \_\_\_\_\_  
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 your work with BD.

\_\_\_\_\_

\_\_\_\_\_

3. Please check any of these chemicals that you work with now or have worked with in the past:

- |  |                          |                                     |                          |
|--|--------------------------|-------------------------------------|--------------------------|
| benzene                                | <input type="checkbox"/> | carbon tetrachloride ("carbon tet") | <input type="checkbox"/> |
| glues                                  | <input type="checkbox"/> | arsine                              | <input type="checkbox"/> |
| toluene                                | <input type="checkbox"/> | carbon disulfide                    | <input type="checkbox"/> |
| inks, dyes                             | <input type="checkbox"/> | lead                                | <input type="checkbox"/> |
| other solvents, grease cutters         | <input type="checkbox"/> | cement                              | <input type="checkbox"/> |
| insecticides (like DDT, lindane, etc.) | <input type="checkbox"/> | petroleum products                  | <input type="checkbox"/> |
| paints, varnishes, thinners, strippers | <input type="checkbox"/> | nitrites                            | <input type="checkbox"/> |
| dusts                                  | <input type="checkbox"/> |                                     |                          |

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

- |                         |                          |
|-------------------------|--------------------------|
| gloves                  | <input type="checkbox"/> |
| coveralls               | <input type="checkbox"/> |
| respirator              | <input type="checkbox"/> |
| dust mask               | <input type="checkbox"/> |
| safety glasses, goggles | <input type="checkbox"/> |

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 | <input type="checkbox"/> |
| Break room/employee lounge     | <input type="checkbox"/> |
| Smoking lounge                 | <input type="checkbox"/> |
| At my work station             | <input type="checkbox"/> |

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

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

1,3 -Butadiene (BD) Update Health Questionnaire

DIRECTIONS:

You have been asked to answer the questions on this form because you work with BD (butadiene). These questions ask about changes in your work, medical history, and health concerns since the last time you were evaluated. 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: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last First MI

Job title: \_\_\_\_\_

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

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

Present Work History

1. Please describe any NEW duties that you have at your job: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Please list any additional job titles you have:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please circle your answer.

3. Are you exposed to any other chemicals in your work since the last time you were evaluated for exposure to BD? yes no  
If yes, please list what they are: \_\_\_\_\_  
\_\_\_\_\_

4. Does your personal protective equipment and clothing fit you properly? yes no

5. Have you made changes in this equipment or clothing to make it fit better? yes no

6. Have you been exposed to BD when you were not wearing protective equipment or clothing?  
 yes no

7. Are you exposed to any NEW chemicals at home or while working on hobbies?  
 yes no

If yes, please list what they are: \_\_\_\_\_  
 \_\_\_\_\_

8. Since your last BD health evaluation, have you started working any new second or side jobs?  
 yes no

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

Personal Health History

1. What is your current weight? \_\_\_\_\_ pounds

2. Have you been diagnosed with any new medical conditions or illness since your last evaluation?  
 yes no

If yes, please tell what they are: \_\_\_\_\_  
 \_\_\_\_\_

3. Since your last evaluation, have you been in the hospital for any illnesses, injuries, or surgery?  
 yes no

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

4. Do you have any of the following? Please place a check for all that apply to you.

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

chest pain \_\_\_\_\_

Please circle your answer.

5. 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: \_\_\_\_\_  
\_\_\_\_\_

6. Have any of your co-workers had similar symptoms or problems? yes no don't know

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

7. Do you notice any irritation of your eyes, nose, throat, lungs, or skin when working with BD? yes no

8. Do you notice any blurred vision, coughing, drowsiness, nausea, or headache when working with BD? yes no

9. Have you been taking any NEW medications (including birth control or over-the-counter)? yes no

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

10. Have you developed any NEW allergies to medications, foods, or chemicals? yes no

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

11. 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: \_\_\_\_\_  
\_\_\_\_\_

12. Did you understand all the questions? yes no

\_\_\_\_\_  
Signature

[61 FR 56831, Nov. 4, 1996, as amended at 63 FR 1294, Jan. 8, 1998; 67 FR 67965, Nov. 7, 2002; 70 FR 1143, Jan. 5, 2005; 71 FR 16672, 16674, Apr. 3, 2006; 73 FR 75587, Dec. 12, 2008; 76 FR 33609, June 8, 2011; 77 FR 17785, Mar. 26, 2012; 78 FR 9313, Feb. 8, 2013]