SIDS - IV mark-up
9/24/18

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	___	carbon tetrachloride ("carbon tet")	___
glues	___	arsine	___
toluene	___	carbon disulfide	___
inks, dyes	___	lead	___
other solvents, grease cutters	___	cement	___
insecticides (like DDT, lindane, etc.)	___	petroleum products	___
paints, varnishes, thinners, strippers	___	nitrites	___
dusts	___		

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. 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	___	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 stools	___	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.

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

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