**Butadiene Standard Appendix F PRA Public Burden Statement**

**§ 1910.1051 1,3-Butadiene.**

Appendix F to § 1910.1051—Medical Questionnaires (Non-Mandatory))

**PAPERWORK REDUCTION ACT STATEMENT**

Under the butadiene (BD) standard, this nonmandatory medical disease questionnaire may be administered to employees with exposure to BD at concentrations at or above the action level on 30 or more days a year or for employees who have or may have exposure to BD at or above the PELs on 10 or more days a year, who will therefore be included in their employer's medical surveillance program. (29 CFR 1910.1051(k)(1)(i)). Under the Paperwork Reduction Act, a Federal agency generally cannot conduct or sponsor, and the public is generally not required to respond to, an information collection, unless it is approved by OMB and 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 30 minutes. 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 consists of time for completion of the questionnaire by the employer’s employee to ensure compliance with the collection of information required in Appendix F. 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](mailto: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; 1218-0170. (This address is for comments regarding this form only; **DO NOT SEND ANY COMPLETED SAMPLE FORM TO THIS OFFICE**.)

*OMB Approval# 1218-0170; Expires: 00-00-0000*

**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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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12. Were you in the military?

yes no

If yes, what did you do in the military? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

yes no

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

yes no

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please check all that apply to you.

unexplained fever \_\_\_\_

anemia ("low blood") \_\_\_\_

HIV/AIDS \_\_\_\_

weakness \_\_\_\_

sickle cell \_\_\_\_

miscarriage \_\_\_\_

skin rash \_\_\_\_

bloody stools \_\_\_\_

leukemia/lymphoma \_\_\_\_

neck mass/swelling \_\_\_\_

wheezing \_\_\_\_

yellowing of skin \_\_\_\_

bruising easily \_\_\_\_

lupus \_\_\_\_

weight loss \_\_\_\_

kidney problems \_\_\_\_

enlarged lymph nodes \_\_\_\_

liver disease \_\_\_\_

cancer \_\_\_\_

infertility \_\_\_\_

drinking problems \_\_\_\_

thyroid problems \_\_\_\_

night sweats \_\_\_\_

chest pain \_\_\_\_

still birth \_\_\_\_

eye redness \_\_\_\_

lumps you can feel \_\_\_\_

child with birth defect \_\_\_\_

autoimmune disease \_\_\_\_

overly tired \_\_\_\_

lung problems \_\_\_\_

rheumatoid arthritis \_\_\_\_

mononucleosis("mono") \_\_\_\_

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

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 \_\_\_\_

anemia ("low blood") \_\_\_\_

HIV/AIDS \_\_\_\_

weakness \_\_\_\_

sickle cell \_\_\_\_

miscarriage \_\_\_\_

skin rash \_\_\_\_

bloody rash \_\_\_\_

leukemia/lymphoma \_\_\_\_

neck mass/swelling \_\_\_\_

wheezing \_\_\_\_

chest pain \_\_\_\_

bruising easily \_\_\_\_

lupus \_\_\_\_

weight loss \_\_\_\_

kidney problems \_\_\_\_

enlarged lymph nodes \_\_\_\_

liver disease \_\_\_\_

cancer \_\_\_\_

infertility \_\_\_\_

drinking problems \_\_\_\_

thyroid problems \_\_\_\_

night sweats \_\_\_\_

still birth \_\_\_\_

eye redness \_\_\_\_

lumps you can feel \_\_\_\_

child with birth defect \_\_\_\_

autoimmune disease \_\_\_\_

overly tired \_\_\_\_

lung problems \_\_\_\_

rheumatoid arthritis \_\_\_\_

mononucleosis "mono" \_\_\_\_

nagging cough \_\_\_\_

yellowing of skin \_\_\_\_

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