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 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

_____

_____

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? _____

_____

_____

_____

12. Were 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 ____

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? _____

   _____

   _____

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