Standards Improvement Project-Phase IV

Asbestos in General Industry Standard Appendix D PRA Public Burden Statement

§ 1910.1001 Asbestos.

APPENDIX D TO § 1910.1001—MEDICAL QUESTIONNAIRES; MANDATORY

PAPERWORK REDUCTION ACT STATEMENT

Under the asbestos in general industry standard, this medical questionnaire must be administered to all employees who are or will be exposed to airborne concentrations of fibers of asbestos at or above the TWA and/or excursion limit, and who will therefore be included in their employer's medical surveillance program. (29 CFR 1910.1001(l)(1)(i), (2), (3)). 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 under the Paperwork Reduction Act and displays a valid OMB Control Number. Use of this questionnaire is mandatory. 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 40 minutes per employee (30 minutes for the initial examinations and 10 minutes for follow-up examinations). 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 D. 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; 1218-0133. (This address is for comments regarding this form only; **DO NOT SEND ANY COMPLETED SAMPLE FORM TO THIS OFFICE**.)

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This mandatory appendix contains the medical questionnaires that must be administered to all employees who are exposed to asbestos above the permissible exposure limit, and who will therefore be included in their employer's medical surveillance program. Part 1 of the appendix contains the Initial Medical Questionnaire, which must be obtained for all new hires who will be covered by the medical surveillance requirements. Part 2 includes the abbreviated Periodical Medical Questionnaire, which must be administered to all employees who are provided periodic medical examinations under the medical surveillance provisions of the standard.

Part 1
INITIAL MEDICAL QUESTIONNAIRE

1. NAME_____

2. CLOCK NUMBER_____

3. PRESENT OCCUPATION_____

4. PLANT _____

5. ADDRESS_____

6. _____
(Zip Code)

7. TELEPHONE NUMBER_____

8. INTERVIEWER_____

9. DATE _____

10. Date of Birth _____
Month Day Year

11. Place of Birth _____

12. Sex
1. Male ___
2. Female ___

13. What is your marital status?
1. Single ___
2. Married ___
3. Widowed ___
4. Separated/ Divorced ___

14. Race (Check all that apply)
1. White ___
2. Black or African American ___
3. Asian ___
4. Hispanic or Latino ___
5. American Indian or Alaska Native ___
6. Native Hawaiian or Other Pacific Islander ___

15. What is the highest grade completed in school? _____
(For example 12 years is completion of high school)

OCCUPATIONAL HISTORY

16A. Have you ever worked full time (30 hours per week or more) for 6 months or more? 1. Yes ___ 2. No ___

IF YES TO 16A:

B. Have you ever worked for a year or more in any dusty job? 1. Yes ___ 2. No ___ 3. Does Not Apply ___

Specify job/industry _____ Total Years Worked ___

Was dust exposure: 1. Mild ___ 2. Moderate ___ 3. Severe ___

C. Have you ever been exposed to gas or chemical fumes in your work? 1. Yes ___ 2. No ___

Specify job/industry _____ Total Years Worked ___

Was exposure: 1. Mild ____ 2. Moderate ___ 3. Severe ___

D. What has been your usual occupation or job—the one you have worked at the longest?

1. Job occupation _____

2. Number of years employed in this occupation _____

3. Position/job title _____

4. Business, field or industry _____

(Record on lines the years in which you have worked in any of these industries, e.g. 1960-1969)

Have you ever worked:	YES	NO
E. In a mine?	_____	_____
F. In a quarry?	_____	_____
G. In a foundry?	_____	_____
H. In a pottery?	_____	_____
I. In a cotton, flax or hemp mill?....	_____	_____
J. With asbestos?	_____	_____

17. <u>PAST MEDICAL HISTORY</u>	YES	NO

A. Do you consider yourself to be in good health? _____ _____

If "NO" state reason _____

B. Have you any defect of vision? _____ _____

If "YES" state nature of defect _____

C. Have you any hearing defect? _____ _____

If "YES" state nature of defect _____

D. Are you suffering from or have you ever suffered from:	YES	NO
a. Epilepsy (or fits, seizures, convulsions)?	_____	_____
b. Rheumatic fever?	_____	_____
c. Kidney disease?	_____	_____
d. Bladder disease?	_____	_____
e. Diabetes?	_____	_____
f. Jaundice?	_____	_____

18. CHEST COLDS AND CHEST ILLNESSES

18A. If you get a cold, does it "usually" go to your chest? (Usually means more than 1/2 the time) — 1. Yes ___ 2. No ___ 3. Don't get colds ___

19A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? — 1. Yes ___ 2. No ___

IF YES TO 19A:

B. Did you produce phlegm with any of these chest illnesses? — 1. Yes ___ 2. No ___ 3. Does Not Apply ___

C. In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more? — Number of illnesses ___ No such illnesses ___

20. Did you have any lung trouble before the age of 16? — 1. Yes ___ 2. No ___

21. Have you ever had any of the following?

1A. Attacks of bronchitis? — 1. Yes ___ 2. No ___

IF YES TO 1A:

B. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
3. Does Not Apply ___

C. At what age was your first attack? Age in Years ___
Does Not Apply ___

2A. Pneumonia (include bronchopneumonia)? 1. Yes ___ 2. No ___

IF YES TO 2A:

B. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
3. Does Not Apply ___

C. At what age did you first have it? Age in Years ___
Does Not Apply ___

3A. Hay Fever? 1. Yes ___ 2. No ___

IF YES TO 3A:

B. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
3. Does Not Apply ___

C. At what age did it start? Age in Years ___
Does Not Apply ___

22A. Have you ever had chronic bronchitis? 1. Yes ___ 2. No ___

IF YES TO 22A:

B. Do you still have it? 1. Yes ___ 2. No ___
3. Does Not Apply ___

C. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
3. Does Not Apply ___

D. At what age did it start? Age in Years ___
Does Not Apply ___

23A. Have you ever had emphysema? 1. Yes ___ 2. No ___

IF YES TO 23A:

B. Do you still have it? 1. Yes ___ 2. No ___
3. Does Not Apply ___

C. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
3. Does Not Apply ___

D. At what age did it start? Age in Years ___
Does Not Apply ___

24A. Have you ever had asthma? 1. Yes ___ 2. No ___

IF YES TO 24A:

B. Do you still have it? 1. Yes ___ 2. No ___
3. Does Not Apply ___

C. Was it confirmed by a doctor? 1. Yes ___ 2. No ___
3. Does Not Apply ___

D. At what age did it start? Age in Years ___
Does Not Apply ___

E. If you no longer have it, at what age did it stop? Age stopped ___
Does Not Apply ___

25. Have you ever had:

A. Any other chest illness? 1. Yes ___ 2. No ___

If yes, please specify _____

B. Any chest operations? 1. Yes ___ 2. No ___

If yes, please specify _____

C. Any chest injuries? 1. Yes ___ 2. No ___

If yes, please specify _____

26A. Has a doctor ever told you that you had heart trouble? 1. Yes ___ 2. No ___

IF YES TO 26A:

B. Have you ever had treatment for heart trouble in the past 10 years? 1. Yes ___ 2. No ___ 3. Does Not Apply ___

27A. Has a doctor told you that you had high blood pressure? 1. Yes ___ 2. No ___

IF YES TO 27A:

B. Have you had any treatment for high blood pressure (hypertension) in the past 10 years? 1. Yes ___ 2. No ___ 3. Does Not Apply ___

28. When did you last have your chest X-rayed? (Year) ___ ___ ___ ___

29. Where did you last have your chest X-rayed (if known)? _____

What was the outcome? _____

FAMILY HISTORY

30. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:	FATHER			MOTHER		
	1. Yes	2. No	3. Don't know	1. Yes	2. No	3. Don't know
A. Chronic Bronchitis?	___	___	___	___	___	___
B. Emphysema?	___	___	___	___	___	___
C. Asthma?	___	___	___	___	___	___
D. Lung cancer?	___	___	___	___	___	___
E. Other chest conditions?	___	___	___	___	___	___
F. Is parent currently alive?	___	___	___	___	___	___
G. Please Specify	___ Age if Living ___ Age at Death ___ Don't Know			___ Age if Living ___ Age at Death ___ Don't Know		
H. Please specify cause of death	_____			_____		

COUGH

31A. Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.) (If no, skip to question 31C.)	1. Yes ___	2. No ___
B. Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week?	1. Yes ___	2. No ___
C. Do you usually cough at all on getting up or first thing in the morning?	1. Yes ___	2. No ___

D. Do you usually cough at all during the rest of the day or at night? 1. Yes ___ 2. No ___

IF YES TO ANY OF ABOVE (31A, B, C, OR D), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO NEXT PAGE

E. Do you usually cough like this on most days for 3 consecutive months or more during the year? 1. Yes ___ 2. No ___ 3. Does not apply ___

F. For how many years have you had the cough? Number of years ___ Does not apply ___

32A. Do you usually bring up phlegm from your chest? Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) (If no, skip to 32C) 1. Yes ___ 2. No ___

B. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week? 1. Yes ___ 2. No ___

C. Do you usually bring up phlegm at all on getting up or first thing in the morning? 1. Yes ___ 2. No ___

D. Do you usually bring up phlegm at all on during the rest of the day or at night? 1. Yes ___ 2. No ___

IF YES TO ANY OF THE ABOVE (32A, B, C, OR D), ANSWER THE FOLLOWING:

IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO 33A

E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year? 1. Yes ___ 2. No ___ 3. Does not apply ___

F. For how many years have you had trouble with phlegm? Number of years ___ Does not apply ___

EPISODES OF COUGH AND PHLEGM

33A. Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year?
*(For persons who usually have cough and/or phlegm)

1. Yes ___ 2. No ___

IF YES TO 33A

B. For how long have you had at least 1 such episode per year?

Number of years ___
Does not apply ___

WHEEZING

34A. Does your chest ever sound wheezy or whistling

1. When you have a cold? 1. Yes ___ 2. No ___

2. Occasionally apart from colds? 1. Yes ___ 2. No ___

3. Most days or nights? 1. Yes ___ 2. No ___

B. For how many years has this been present?

Number of years ___
Does not apply ___

35A. Have you ever had an attack of wheezing that has made you feel short of breath? 1. Yes ___ 2. No ___

IF YES TO 35A

B. How old were you when you had your first such attack?

Age in years ___
Does not apply ___

C. Have you had 2 or more such episodes? 1. Yes ___ 2. No ___
3. Does not apply ___

D. Have you ever required medicine or treatment for the(se) attack(s)? 1. Yes ___ 2. No ___
3. Does not apply ___

BREATHLESSNESS

36. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 38A.

Nature of condition(s)
_____
_____

37A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

1. Yes ___ 2. No ___

IF YES TO 37A

B. Do you have to walk slower than people of your age on the level because of breathlessness?

1. Yes ___ 2. No ___
3. Does not apply ___

C. Do you ever have to stop for breath when walking at your own pace on the level?

1. Yes ___ 2. No ___
3. Does not apply ___

D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?

1. Yes ___ 2. No ___
3. Does not apply ___

E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs?

1. Yes ___ 2. No ___
3. Does not apply ___

TOBACCO SMOKING

38A. Have you ever smoked cigarettes?
(No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year.)

1. Yes ___ 2. No ___

IF YES TO 38A

B. Do you now smoke cigarettes (as of one month ago)

1. Yes ___ 2. No ___
3. Does not apply ___

C. How old were you when you first started regular cigarette smoking?

Age in years ___
Does not apply ___

D. If you have stopped smoking cigarettes completely, how old were you when you stopped?

Age stopped ___
Check if still smoking ___
Does not apply ___

E. How many cigarettes do you smoke per day now?

Cigarettes per day ___
Does not apply ___

F. On the average of the entire time you smoked, how many cigarettes did you smoke per day?

Cigarettes per day ___
Does not apply ___

G. Do or did you inhale the cigarette smoke?

1. Does not apply ___
2. Not at all ___
3. Slightly ___
4. Moderately ___
5. Deeply ___

39A. Have you ever smoked a pipe regularly?
(Yes means more than 12 oz. of tobacco in a lifetime.)

1. Yes ___ 2. No ___

IF YES TO 39A:
<u>FOR PERSONS WHO HAVE EVER SMOKED A PIPE</u>

B. 1. How old were you when you started to smoke a pipe regularly?

Age ___

2. If you have stopped smoking a pipe completely, how old were you when you stopped?

Age stopped ___
Check if still smoking pipe ___
Does not apply ___

C. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week?

___ oz. per week (a standard pouch of tobacco contains 1 1/2 oz.)

___ Does not apply

D. How much pipe tobacco are you smoking now?

oz. per week ___
Not currently smoking a pipe ___

E. Do you or did you inhale the pipe smoke?

1. Never smoked ___
2. Not at all ___
3. Slightly ___
4. Moderately ___
5. Deeply ___

40A. Have you ever smoked cigars regularly?

1. Yes ___ 2. No ___

(Yes means more than 1 cigar a week for a year)

IF YES TO 40A

<u>FOR PERSONS WHO HAVE EVER SMOKED A CIGAR</u>

B. 1. How old were you when you started smoking cigars regularly?

Age ___

2. If you have stopped smoking cigars completely, how old were you when you stopped smoking cigars?

Age stopped ___
Check if still ___
Does not apply ___

C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week?

Cigars per week ___
Does not apply ___

D. How many cigars are you smoking per week now?

Cigars per week ___
Check if not smoking cigars currently ___

E. Do or did you inhale the cigar smoke?

1. Never smoked ___
2. Not at all ___
3. Slightly ___
4. Moderately ___
5. Deeply ___

Signature _____ Date _____

.

Part 2

PERIODIC MEDICAL QUESTIONNAIRE

1. NAME _____

2. CLOCK NUMBER ___ ___ ___ ___ ___ ___ ___

3. PRESENT OCCUPATION _____

4. PLANT _____

5. ADDRESS _____

6. _____
(Zip Code)

7. TELEPHONE NUMBER _____

8. INTERVIEWER _____

9. DATE _____

10. What is your marital status? 1. Single ___ 4. Separated/
2. Married ___ Divorced ___
3. Widowed ___

11. <u>OCCUPATIONAL HISTORY</u>

11A. In the past year, did you work full time (30 hours per week or more) for 6 months or more? 1. Yes ___ 2. No ___

IF YES TO 11A:

11B. In the past year, did you work in a dusty job? 1. Yes ___ 2. No ___
3. Does not Apply ___

11C. Was dust exposure: 1. Mild ___ 2. Moderate ___ 3. Severe ___

11D. In the past year, were you exposed to gas or chemical fumes in your work? 1. Yes ___ 2. No ___

11E. Was exposure: 1. Mild ___ 2. Moderate ___ 3. Severe ___

11F. In the past year,
what was your: 1. Job/occupation? _____
2. Position/job title? _____

12. RECENT MEDICAL HISTORY

12A. Do you consider yourself to be in good health? Yes ___ No ___

If NO, state reason _____

12B. In the past year, have you developed:

	Yes	No
Epilepsy?	___	___
Rheumatic fever?	___	___
Kidney disease?	___	___
Bladder disease?	___	___
Diabetes?	___	___
Jaundice?	___	___
Cancer?	___	___

13. CHEST COLDS AND CHEST ILLNESSES

13A. If you get a cold, does it "usually" go to your chest? (usually means more than 1/2 the time)

1. Yes ___ 2. No ___
3. Don't get colds ___

14A. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? 1. Yes ___ 2. No ___ 3. Does Not Apply ___

IF YES TO 14A:

14B. Did you produce phlegm with any of these chest illnesses? 1. Yes ___ 2. No ___ 3. Does Not Apply ___

14C. In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more? Number of illnesses ___ No such illnesses ___

15. RESPIRATORY SYSTEM

In the past year have you had:

	Yes or No	Further Comment on Positive Answers
Asthma	_____	
Bronchitis	_____	
Hay Fever	_____	
Other Allergies	_____	

	Yes or No	Further Comment on Positive Answers
Pneumonia	_____	
Tuberculosis	_____	
Chest Surgery	_____	
Other Lung Problems	_____	
Heart Disease	_____	

Do you have:

	Yes or No	Further Comment on Positive Answers
Frequent colds	_____	
Chronic cough	_____	
Shortness of breath when walking or climbing one flight or stairs	_____	

Do you:

Wheeze	_____	
Cough up phlegm	_____	
Smoke cigarettes	_____	Packs per day ____ How many years ___

Date _____ Signature _____