

## Asbestos in Shipyards Standard Appendix D PRA Public Burden Statement

### § 1915.1001 Asbestos.

#### APPENDIX D TO § 1915.1001—MEDICAL QUESTIONNAIRES; MANDATORY

##### PAPERWORK REDUCTION ACT STATEMENT

Under the asbestos in shipyards standard, this medical questionnaire must be administered to all employees who are exposed to asbestos, tremolite, anthophyllite, actinolite, or a combination of these minerals above the permissible exposure limit (0.1 f/cc), and who will therefore be included in their employer's medical surveillance program. (29 CFR 1915.1001(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](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; 1218-0195. (This address is for comments regarding this form only; **DO NOT SEND ANY COMPLETED SAMPLE FORM TO THIS OFFICE.**)

*OMB Approval# 1218-0195; Expires: 00-00-0000*

This mandatory appendix contains the medical questionnaires that must be administered to all employees who are exposed to asbestos, tremolite, anthophyllite, actinolite, or a combination of these minerals above the permissible exposure limit (0.1 f/cc), 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 \_\_\_\_ 4. Separated/  
2. Married \_\_\_\_ Divorced \_\_\_\_  
3. Widowed \_\_\_\_

14. Race (Check all that apply)  
1. White \_\_\_\_ 4. Hispanic or Latino \_\_\_\_  
2. Black or African American \_\_\_\_ 5. American Indian or  
Alaska Native \_\_\_\_  
3. Asian \_\_\_\_ 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. PAST MEDICAL HISTORY

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 if Living		
	___ Age at Death			___ Age at Death		
	___ Don't Know			___ 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? 1. Yes \_\_\_ 2. No \_\_\_  
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)

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? 1. Yes \_\_\_ 2. No \_\_\_  
\*(For persons who usually have cough and/or phlegm)

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? 1. Yes \_\_\_ 2. No \_\_\_  
(Yes means more than 12 oz. of tobacco in a lifetime.)

**IF YES TO 39A:  
FOR PERSONS WHO HAVE EVER SMOKED A PIPE**

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

FOR PERSONS WHO HAVE EVER SMOKED A CIGAR

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. OCCUPATIONAL HISTORY

- 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:

	<u>Yes</u>	<u>No</u>
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:

	<u>Yes or No</u>	<u>Further Comment on Positive Answers</u>
Asthma	_____	
Bronchitis	_____	
Hay Fever	_____	
Other Allergies	_____	

	<u>Yes or No</u>	<u>Further Comment on Positive Answers</u>
Pneumonia	_____	
Tuberculosis	_____	
Chest Surgery	_____	
Other Lung Problems	_____	
Heart Disease	_____	
Do you have:		

	<u>Yes or No</u>	<u>Further Comment on Positive Answers</u>
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 \_\_\_\_\_