Formaldehyde Standard Appendix D PRA Public Burden Statement

§ 1910.1048 Formaldehyde.

APPENDIX D TO § 1910.1048—NONMANDATORY MEDICAL DISEASE QUESTIONNAIRE

PAPERWORK REDUCTION ACT STATEMENT

Under the formaldehyde standard, this nonmandatory medical disease questionnaire may be administered to employees who are included in their employer's medical surveillance program. (29 CFR 1910.1048(l)(1)). 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 60 minutes (1 hour). 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 includes employer time for compliance with the underlying information collection requirements in 29 CFR 1910.1048(l), including employee time for completion of the questionnaire and medical examination and providing information to the physician. 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; 1218-0145. (This address is for comments regarding this form only; **DO NOT SEND ANY COMPLETED SAMPLE FORM TO THIS OFFICE**.)

OMB Approval# 1218-0145; Expires: 00-00-0000

A. Identification

Plant Name: ____________________

Date: ____________________

Employee Name: ____________________

Job Title: ____________________

Birthdate: ____________________

Age: ____________________

Sex: ____________________

Height: ____________________

Weight: ____________________

B. Medical History

1. Have you ever been in the hospital as a patient?

Yes__ No__

If yes, what kind of problem were you having?

____
____

2. Have you ever had any kind of operation?

   Yes__ No__

   If yes, what kind?

   ____
   ____

3. Do you take any kind of medicine regularly?

   Yes__ No__

   If yes, what kind?

   ____
   ____

4. Are you allergic to any drugs, foods, or chemicals?

   Yes__ No__

   If yes, what kind of allergy is it?

   ____
   ____

   What causes the allergy?

   ____
   ____

5. Have you ever been told that you have asthma, hayfever, or sinusitis?

   Yes__ No__

6. Have you ever been told that you have emphysema, bronchitis, or any other respiratory problems?

   Yes__ No__

7. Have you ever been told you had hepatitis?

   Yes__ No__

8. Have you ever been told that you had cirrhosis?

   Yes__ No__

9. Have you ever been told that you had cancer?

   Yes__ No__

10. Have you ever had arthritis or joint pain?

   Yes__ No__

11. Have you ever been told that you had high blood pressure?

   Yes__ No__

12. Have you ever had a heart attack or heart trouble?

   Yes__ No__

B-1. Medical History Update

1. Have you been in the hospital as a patient any time within the past year?

   Yes__ No__

   If so, for what condition?

   ____

   ____

2. Have you been under the care of a physician during the past year?

   Yes__ No__

   If so, for what condition?

   ____

   ____

3. Is there any change in your breathing since last year?

   Yes__ No__

   Better? ____

   Worse? ____

   No change?____

   If change, do you know why?

   ____

   ____

4. Is your general health different this year from last year?

   Yes__ No__

If different, in what way?

____

____

5. Have you in the past year or are you now taking any medication on a regular basis?

Yes__ No__

Name Rx____

Condition being treated ____

C. Occupational History

1. How long have you worked for your present employer?

____

2. What jobs have you held with this employer? Include job title and length of time in each job

____

____

____

____

3. In each of these jobs, how many hours a day were you exposed to chemicals?

____

4. What chemicals have you worked with most of the time?

____

5. Have you ever noticed any type of skin rash you feel was related to your work?

Yes__ No__

6. Have you ever noticed that any kind of chemical makes you cough?

Yes__ No__

Wheeze?

Yes__ No__

Become short of breath or cause your chest to become tight?

Yes__ No__

7. Are you exposed to any dust or chemicals at home?

Yes__ No__

If yes, explain:

____

____

8. In other jobs, have you ever had exposure to:

   Wood dust?

   Yes__ No__

   Nickel or chromium?

   Yes__ No__

   Silica (foundry, sand blasting)?

   Yes__ No__

   Arsenic or asbestos?

   Yes__ No__

   Organic solvents?

   Yes__ No__

   Urethane foams?

   Yes__ No__

C-1. Occupational History Update

1. Are you working on the same job this year as you were last year?

   Yes__ No__

   If not, how has your job changed?

   ____

   ____

2. What chemicals are you exposed to on your job?

   ____

3. How many hours a day are you exposed to chemicals?

   ____

4. Have you noticed any skin rash within the past year you feel was related to your work?

Yes__ No__

If so, explain circumstances:

____

____

5. Have you noticed that any chemical makes you cough, be short of breath, or wheeze?

Yes__ No__

If so, can you identify it?

____

____

D. Miscellaneous

1. Do you smoke?

Yes__ No__

If so, how much and for how long?

____

____

Pipe____

Cigars____

Cigarettes____

2. Do you drink alcohol in any form?

Yes__ No__

If so, how much, how long, and how often?

____

____

3. Do you wear glasses or contact lenses?

Yes__ No__

4. Do you get any physical exercise other than that required to do your job?

Yes__ No__

If so, explain:

____

____

5. Do you have any hobbies or "side jobs" that require you to use chemicals, such as furniture stripping, sand blasting, insulation or manufacture of urethane foam, furniture, etc.?

   Yes__ No__

   If so, please describe, giving type of business or hobby, chemicals used and length of exposures.

   ____

E. Symptoms Questionnaire

1. Do you ever have any shortness of breath?

   Yes__ No__

   If yes, do you have to rest after climbing several flights of stairs?

   Yes__ No__

   If yes, if you walk on the level with people your own age, do you walk slower than they do?

   Yes__ No__

   If yes, if you walk slower than a normal pace, do you have to limit the distance that you walk?

   Yes__ No__

   If yes, do you have to stop and rest while bathing or dressing?

   Yes__ No__

2. Do you cough as much as three months out of the year?

   Yes__ No__

   If yes, have you had this cough for more than two years?

   Yes__ No__

   If yes, do you ever cough anything up from chest?

   Yes__ No__

3. Do you ever have a feeling of smothering, unable to take a deep breath, or tightness in your chest?

   Yes__ No__

   If yes, do you notice that this on any particular day of the week?

Yes__ No__

If yes, what day or the week?

Yes__ No__

If yes, do you notice that this occurs at any particular place?

Yes__ No__

If yes, do you notice that this is worse after you have returned to work after being off for several days?

Yes__ No__

4. Have you ever noticed any wheezing in your chest?

   Yes__ No__

   If yes, is this only with colds or other infections?

   Yes__ No__

   Is this caused by exposure to any kind of dust or other material?

   Yes__ No__

   If yes, what kind? ____

5. Have you noticed any burning, tearing, or redness of your eyes when you are at work?

   Yes__ No__

   If so, explain circumstances: ____

   ____

6. Have you noticed any sore or burning throat or itchy or burning nose when you are at work?

   Yes__ No__

   If so, explain circumstances:

   ____

   ____

7. Have you noticed any stuffiness or dryness of your nose?

   Yes__ No__

8. Do you ever have swelling of the eyelids or face?

Yes__ No__

9. Have you ever been jaundiced?

   Yes__ No__

   If yes, was this accompanied by any pain?

   Yes__ No__

10. Have you ever had a tendency to bruise easily or bleed excessively?

    Yes__ No__

11. Do you have frequent headaches that are not relieved by aspirin or Tylenol?

    Yes__ No__

    If yes, do they occur at any particular time of the day or week?

    Yes__ No__

    If yes, when do they occur?
    ____
    ____

12. Do you have frequent episodes of nervousness or irritability?

    Yes__ No__

13. Do you tend to have trouble concentrating or remembering?

    Yes__ No__

14. Do you ever feel dizzy, light-headed, excessively drowsy or like you have been drugged?

    Yes__ No__

15. Does your vision ever become blurred?

    Yes__ No__

16. Do you have numbness or tingling of the hands or feet or other parts of your body?

    Yes__ No__

17. Have you ever had chronic weakness or fatigue?

    Yes__ No__

18. Have you ever had any swelling of your feet or ankles to the point where you could not wear your shoes?

    Yes__ No__

19. Are you bothered by heartburn or indigestion?

    Yes__ No__

20. Do you ever have itching, dryness, or peeling and scaling of the hands?

    Yes__ No__

21. Do you ever have a burning sensation in the hands, or reddening of the skin?

    Yes__ No__

22. Do you ever have cracking or bleeding of the skin on your hands?

    Yes__ No__

23. Are you under a physician's care?

    Yes__ No__

    If yes, for what are you being treated?

    ____

    ____

24. Do you have any physical complaints today?

    Yes__ No__

    If yes, explain?

    ____

    ____

25. Do you have other health conditions not covered by these questions?

    Yes__ No__

    If yes, explain:

    ____

    ____