

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 Control # 1218-0170; Expiration Date: 9-30-2026

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

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