

Appendix D to §1910.1001 - Medical Questionnaires - Mandatory

Part 2

PERIODIC MEDICAL QUESTIONNAIRE:

- 1. NAME: _____
- 2. SOCIAL SECURITY NUMBER: _____
- 3. CLOCK NUMBER: _____
- 4. PRESENT OCCUPATION: _____
- 5. PLANT: _____
- 6. ADDRESS: _____
- 7. CITY: _____ ST: _____ ZIP CODE: _____
- 8. TELEPHONE NUMBER: (_____) _____ - _____ EXT. _____
- 9. INTERVIEWER: _____
- 10. DATE: ____ / ____ / ____

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

12. OCCUPATIONAL HISTORY

- 12A. 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 12A:
- 12B. In the past year, did you work in a dusty job? 1. Yes 2. No 3. Does Not Apply
- 12C. Was dust exposure: 1. Mild 2. Moderate 3. Severe
- 12D. In the past year, were you exposed to gas or chemical fumes in your work? 1. Yes 2. No
- 12E. Was exposure: 1. Mild 2. Moderate 3. Severe
- 12F. In the past year, what was your:
1. Job/Occupation? _____
2. Position/Job Title? _____

13. RECENT MEDICAL HISTORY

- 13A. Do you consider yourself to be in good health? 1. Yes 2. No
If "No", state reason: _____
- 13B. In the past year, have you developed:
Epilepsy? Yes No
Rheumatic Fever? Yes No
Kidney Disease? Yes No
Bladder Disease? Yes No
Diabetes? Yes No
Jaundice? Yes No
Cancer? Yes No

14. CHEST COLDS AND CHEST ILLNESSES

- 14A. 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
- 15A. 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 15A:
- 15B. Did you produce phlegm with any of these chest illnesses? 1. Yes 2. No 3. Does Not Apply
- 15C. 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

16. RESPIRATORY SYSTEM

- | | | |
|---|--|---|
| In the past year have you had: | | Further Comment on Positive Answers |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Other Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Chest Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Other Lung Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Do You Have: | | |
| Frequent Colds | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Chronic Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Shortness Of Breath When Walking Or Climbing One Flight Of Stairs | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Do you: | | |
| Wheeze | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Cough Up Phlegm | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Smoke Cigarettes | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ Packs Per Day _____ How Many Years |

Date: ____ / ____ / ____

Signature _____