

§5202. Methylene Chloride, Appendix B
Questionnaire For Methylene Chloride Exposure

I. DEMOGRAPHIC INFORMATION

1. NAME: _____ 2. SOCIAL SECURITY NUMBER: _____
3. DATE: _____ / _____ / _____ 4. DATE OF BIRTH: _____ / _____ / _____ 5. AGE: _____
MONTH DAY YEAR MONTH DAY YEAR
6. PRESENT OCCUPATION: _____
7. SEX: M F 8. RACE: W N IND OTHER

II. OCCUPATIONAL HISTORY

1. Have you ever worked with methylene chloride, dichloromethane, methylene dichloride, or CH₂Cl₂ (all are different names for the same chemical)? Yes No
Please list which on the occupational history form if you have not already.
2. If you have worked in any of the following industries and have not listed them on the occupational history form, please do so.
- | | |
|--|--|
| Furniture stripping | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Polyurethane foam manufacturing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical manufacturing or formulation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pharmaceutical manufacturing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any industry in which you used solvents to clean and degrease equipment or parts | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Construction, especially painting and refinishing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Aerosol manufacturing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any industry in which you used aerosol adhesives | <input type="checkbox"/> Yes <input type="checkbox"/> No |
3. If you have not listed hobbies or household projects on the occupational history form, especially furniture refinishing, spray painting, or paint stripping, please do so.

III. MEDICAL HISTORY

A. General

1. Do you consider yourself to be in good health? If no, state reason(s). _____
2. Do you or have you ever had:
- a. Persistent thirst b. Frequent urination (three times or more at night) c. Dermatitis or irritated skin d. Non-healing wounds
3. What prescription or non-prescription medications do you take, and for what reasons? _____
4. Are you allergic to any medications, Yes No and what type of reaction do you have? _____

B. Respiratory

1. Do you have or have you ever had any chest illnesses or diseases? Explain: _____
2. Do you have or have you ever had any of the following: a. Asthma b. Wheezing c. Shortness of breath
3. Have you ever had an abnormal chest X-ray? Yes No
If so, when, where, and what were the findings? _____
4. Have you ever had difficulty using a respirator or breathing apparatus? Yes No
Explain: _____
5. Do any chest or lung diseases run in your family? Yes No
Explain: _____
6. Have you ever smoked cigarettes, cigars, or a pipe? Yes No Age started: _____
7. Do you now smoke? Yes No
8. If you have stopped smoking completely, how old were you when you stopped? _____
9. On the average of the entire time you smoked, how many packs of cigarettes, cigars, or bowls of tobacco did you smoke per day? _____

C. Cardiovascular

1. Have you ever been diagnosed with any of the following: Which of the following apply to you now or did apply to you at some time in the past, even if the problem is controlled by medication? Please explain any yes answers (i.e., when problem was diagnosed, length of time on medication).
- a. High cholesterol or triglyceride level Yes No
Explain: _____
- b. Hypertension (high blood pressure) Yes No
Explain: _____
- c. Diabetes Yes No
Explain: _____
- d. Family history of heart attack, stroke, or blocked arteries Yes No
Explain: _____
2. Have you ever had chest pain? Yes No If so, answer the next five questions.
- a. What was the quality of the pain (i.e., crushing, stabbing, squeezing)? _____
- b. Did the pain go anywhere (i.e., into jaw, left arm)? _____
- c. What brought the pain out? _____
- d. How long did it last? _____
- e. What made the pain go away? _____
3. Have you ever had heart disease, a heart attack, stroke, aneurysm, or blocked arteries anywhere in your body? Yes No
Explain (when, treatment): _____

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Questionnaire For Methylene Chloride Exposure (Continued)

C. Cardiovascular (continued)

4. Have you ever had bypass surgery for blocked arteries in your heart or anywhere else? Yes No
Explain: _____
5. Have you ever had any other procedures done to open up a blocked artery (balloon angioplasty, carotid endarterectomy, clot-dissolving drug)? Yes No
Explain: _____
6. Do you have or have you ever had (explain each):
- a. Heart murmur Yes No
Explain: _____
- b. Irregular heartbeat Yes No
Explain: _____
- c. Shortness of breath while lying flat Yes No
Explain: _____
- d. Congestive heart failure Yes No
Explain: _____
- e. Ankle swelling Yes No
Explain: _____
- f. Recurrent pain anywhere below the waist while walking Yes No
Explain: _____
7. Have you ever had an electrocardiogram (EKG)? Yes No
When? DATE: ____ / ____ / ____
8. Have you ever had an abnormal EKG? Yes No
If so, when, where, and what were the findings? _____
9. Do any heart diseases, high blood pressure, diabetes, high cholesterol, or high triglycerides run in your family? Yes No
Explain: _____

D. Hepatobiliary and Pancreas

1. Do you now or have you ever drunk alcoholic beverages? Yes No Age Started ____ Age Stopped ____
2. Average numbers per week: a. Beers: ____ ounces in usual container b. Glasses of wine: ____ ounces per glass c. Drinks: ____ ounces in usual container
3. Do you have or have you ever had (explain each):
- a. Hepatitis (infectious, autoimmune, drug-induced, or chemical) Yes No
Explain: _____
- b. Jaundice Yes No
Explain: _____
- c. Elevated liver enzymes or elevated bilirubin Yes No
Explain: _____
- d. Liver disease or cancer Yes No
Explain: _____

E. Central Nervous System

1. Do you or have you ever had (explain each):
- a. Headache Yes No
Explain: _____
- b. Dizziness Yes No
Explain: _____
- c. Fainting Yes No
Explain: _____
- d. Loss of consciousness Yes No
Explain: _____
- e. Garbled speech Yes No
Explain: _____
- f. Lack of balance Yes No
Explain: _____
- g. Mental/psychiatric illness Yes No
Explain: _____
- h. Forgetfulness Yes No
Explain: _____

F. Hematologic

1. Do you have, or have you ever had (explain each):
- a. Anemia Yes No
Explain: _____
- b. Sickle cell disease or trait Yes No
Explain: _____
- c. Glucose-6-phosphate dehydrogenase deficiency Yes No
Explain: _____
- d. Bleeding tendency disorder Yes No
Explain: _____
2. If not already mentioned previously, have you ever had a reaction to sulfa drugs or to drugs used to prevent or treat malaria? Yes No
What was the drug? Describe the reaction: _____

