

**§5217. Formaldehyde, Appendix D**  
**Nonmandatory Medical Disease Questionnaire**

**A. IDENTIFICATION DATA**

PLANT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
MONTH DAY YEAR

EMPLOYEE NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ JOB TITLE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE: \_\_\_\_ SEX: M.  F.  HEIGHT: \_\_\_\_ FEET \_\_\_\_ INCHES WEIGHT: \_\_\_\_ LBS.  
MONTH DAY YEAR

**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 that 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? \_\_\_\_\_

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**Nonmandatory Medical Disease Questionnaire (continued)**

**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 the 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 this condition on any particular day of the week?  Yes  No  
If Yes, what day of the week? \_\_\_\_\_  
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: \_\_\_\_\_