- **Part Number:** 1910
- **Part Title:** Occupational Safety and Health Standards
- **Subpart:** Z
- **Subpart Title:** Toxic and Hazardous Substances
- **Standard Number:** 1910.1051 App F
- **Title:** Medical Questionnaires, (Non-mandatory)

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

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

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