Appendix F to §1910.1051
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: ___/___/___
MONTH DAY YEAR

NAME: _____ _____ ___
LAST FIRST MIDDLE INITIAL

JOB TITLE: _____

COMPANY'S NAME: _____

SUPERVISOR'S NAME: _____

SUPERVISOR'S PHONE NO.: (___) ___ - ____ EXT. ____

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 your 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
- ☐ Respirator
- ☐ Safety glasses, goggles
- ☐ Coveralls
- ☐ Dust mask

Please check 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

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? _____

_____

_____

_____

Appendix F to §1910.1051
Medical Questionnaires (Non-Mandatory) (continued)

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:

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

Please check 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	☐ Bruising easily	☐ Still birth	☐ Anemia ("low blood")	☐ Lupus
☐ Eye redness	☐ HIV/AIDS	☐ Weight loss	☐ Lumps you can feel	☐ Weakness
☐ Kidney problems	☐ Child with birth defect	☐ Sickle cell	☐ Enlarged lymph nodes	☐ Autoimmune disease
☐ Miscarriage	☐ Liver disease	☐ Overly tired	☐ Skin rash	☐ Cancer
☐ Lung problems	☐ Bloody stools	☐ Infertility	☐ Rheumatoid arthritis	☐ Leukemia/lymphoma
☐ Drinking problems	☐ Mononucleosis ("mono")	☐ Neck mass/swelling	☐ Thyroid problems	☐ Nagging cough
☐ Wheezing	☐ Night sweats	☐ Yellowing of skin	☐ Chest pain	

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: ___ / ___ / ___
MONTH DAY YEAR

NAME: _____ _____ ___
LAST FIRST MIDDLE INITIAL

JOB TITLE: _____

COMPANY'S NAME: _____

SUPERVISOR'S NAME: _____

SUPERVISOR'S PHONE NO.: (___) ___ - ____ EXT. ____

PRESENT WORK HISTORY:

1. Please describe any NEW duties that you have at your job: _____
2. Please list any additional job titles you have: _____
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? ___ lbs.
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 check all that apply to you.

☐ Unexplained fever	☐ Bruising easily	☐ Still birth	☐ Anemia ("low blood")	☐ Lupus
☐ Eye redness	☐ HIV/AIDS	☐ Weight loss	☐ Lumps you can feel	☐ Weakness
☐ Kidney problems	☐ Child with birth defect	☐ Sickle cell	☐ Enlarged lymph nodes	☐ Autoimmune disease
☐ Miscarriage	☐ Liver disease	☐ Overly tired	☐ Skin rash	☐ Cancer
☐ Lung problems	☐ Bloody stools	☐ Infertility	☐ Rheumatoid arthritis	☐ Leukemia/lymphoma
☐ Drinking problems	☐ Mononucleosis ("mono")	☐ Neck mass/swelling	☐ Thyroid problems	☐ Nagging cough
☐ Wheezing	☐ Night sweats	☐ Yellowing of skin	☐ Chest pain	

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 medication, 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