

WAC 296-62-07548 Appendix D—Nonmandatory medical disease questionnaire. (1) Identification.

- (a) Plant name:
- (b) Date:
- (c) Employee name:
- (d) Social Security number:
- (e) Job title:
- (f) Birthdate:
- (g) Age:
- (h) Sex:
- (i) Height:
- (j) Weight:
- (2) Medical history.
 - (a) Have you ever been in the hospital as a patient?
Yes No
If yes, what kind of problem were you having?
 - (b) Have you ever had any kind of operation?
Yes No
If yes, what kind?
 - (c) Do you take any kind of medicine regularly?
Yes No
If yes, what kind?
 - (d) Are you allergic to any drugs, foods, or chemicals?
Yes No
If yes, what kind of allergy is it?
What causes the allergy?
 - (e) Have you ever been told that you have asthma, hayfever, or sinusitis?
Yes No
 - (f) Have you ever been told that you have emphysema, bronchitis, or any other respiratory problems?
Yes No
 - (g) Have you ever been told you had hepatitis?
Yes No
 - (h) Have you ever been told that you have cirrhosis?
Yes No
 - (i) Have you ever been told that you had cancer?
Yes No
 - (j) Have you ever had arthritis or joint pain?
Yes No
 - (k) Have you ever been told that you had high blood pressure?
Yes No
 - (l) Have you ever had a heart attack or heart trouble?
Yes No
- (3) Medical history update.
 - (a) Have you been in the hospital as a patient any time within the past year?
Yes No
If so, for what condition?
 - (b) Have you been under the care of a physician during the past year?
Yes No
If so, for what condition?

- (c) Is there any change in your breathing since last year?
 Yes No
 (i) Better?
 (ii) Worse?
 (iii) No change?
 If change, do you know why?
- (d) Is your general health different this year from last year?
 Yes No
 If different, in what way?
- (e) Have you in the past year or are you now taking any medication on a regular basis?
 Yes No
 (i) Name Rx
 (ii) Condition being treated
- (4) Occupational history.
- (a) How long have you worked for your present employer?
- (b) What jobs have you held with this employer? Include job title and length of time in each job.
- (c) In each of these jobs, how many hours a day were you exposed to chemicals?
- (d) What chemicals have you worked with most of the time?
- (e) Have you ever noticed any type of skin rash you feel was related to your work?
 Yes No
- (f) Have you ever noticed that any kind of chemical makes you cough?
 Yes No
 (i) Wheeze:
 Yes No
 (ii) Become short of breath or cause your chest to become tight?
 Yes No
- (g) Are you exposed to any dust or chemicals at home?
 Yes No
 If yes, explain:
- (h) In other jobs, have you ever had exposure to:
 (i) Wood dust?
 Yes No
 (ii) Nickel or chromium?
 Yes No
 (iii) Silica (foundry, sand blasting)?
 Yes No
 (iv) Arsenic or asbestos?
 Yes No
 (v) Organic solvents?
 Yes No
 (vi) Urethane foams?
 Yes No
- (5) Occupational history update.
- (a) Are you working on the same job this year as you were last year?
 Yes No
 If not, how has your job changed?
- (b) What chemicals are you exposed to on your job?
- (c) How many hours a day are you exposed to chemicals?

- (d) Have you noticed any skin rash within the past year you feel was related to your work?
 Yes No
 If so, explain circumstances:
- (e) Have you noticed that any chemical makes you cough, be short of breath, or wheeze?
 Yes No
 If so, can you identify it?
- (6) Miscellaneous.
- (a) Do you smoke?
 Yes No
 If so, how much and for how long?
 (i) Pipe
 (ii) Cigars
 (iii) Cigarettes
- (b) Do you drink alcohol in any form?
 Yes No
 If so, how much, how long, and how often?
- (c) Do you wear glasses or contact lenses?
 Yes No
- (d) Do you get any physical exercise other than that required to do your job?
 Yes No
 If so, explain:
- (e) 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.
- (7) Symptoms questionnaire.
- (a) Do you ever have any shortness of breath?
 Yes No
 (i) If yes, do you have to rest after climbing several flights of stairs?
 Yes No
 (ii) If yes, if you walk on the level with people your own age, do you walk slower than they do?
 Yes No
 (iii) If yes, if you walk slower than a normal pace, do you have to limit the distance that you walk?
 Yes No
 (iv) If yes, do you have to stop and rest while bathing or dressing?
 Yes No
- (b) Do you cough as much as three months out of the year?
 Yes No
 (i) If yes, have you had this cough for more than two years?
 Yes No
 (ii) If yes, do you ever cough anything up from the chest?
 Yes No

- (c) Do you ever have a feeling of smothering, unable to take a deep breath, or tightness in your chest?
 Yes No
 (i) If yes, do you notice that this occurs on any particular day of the week?
 Yes No
 (ii) If yes, what day of the week?
 (iii) If yes, do you notice that this occurs at any particular place?
 Yes No
 (iv) If yes, do you notice that this is worse after you have returned to work after being off for several days?
 Yes No
- (d) Have you ever noticed any wheezing in your chest?
 Yes No
 (i) If yes, is this only with colds or other infections?
 Yes No
 (ii) Is this caused by exposure to any kind of dust or other material?
 Yes No
 (iii) If yes, what kind?
- (e) Have you noticed any burning, tearing, or redness of your eyes when you are at work?
 Yes No
 If so, explain circumstances:
- (f) Have you noticed any sore or burning throat or itchy or burning nose when you are at work?
 Yes No
 If so, explain circumstances:
- (g) Have you noticed any stuffiness or dryness of your nose?
 Yes No
- (h) Do you ever have swelling of the eyelids or face?
 Yes No
- (i) Have you ever been jaundiced?
 Yes No
 If yes, was this accompanied by any pain?
 Yes No
- (j) Have you ever had a tendency to bruise easily or bleed excessively?
 Yes No
- (k) Do you have frequent headaches that are not relieved by aspirin or tylenol?
 Yes No
 (i) If yes, do they occur at any particular time of the day or week?
 Yes No
 (ii) If yes, when do they occur?
- (l) Do you have frequent episodes of nervousness or irritability?
 Yes No
- (m) Do you tend to have trouble concentrating or remembering?
 Yes No
- (n) Do you ever feel dizzy, light-headed, excessively drowsy, or like you have been drugged?
 Yes No
- (o) Does your vision ever become blurred?
 Yes No

- (p) Do you have numbness or tingling of the hands or feet or other parts of your body?
Yes No
- (q) Have you ever had chronic weakness or fatigue?
Yes No
- (r) Have you ever had any swelling of your feet or ankles to the point where you could not wear your shoes?
Yes No
- (s) Are you bothered by heartburn or indigestion?
Yes No
- (t) Do you ever have itching, dryness, or peeling and scaling of the hands?
Yes No
- (u) Do you ever have a burning sensation in the hands, or reddening of the skin?
Yes No
- (v) Do you ever have cracking or bleeding of the skin on your hands?
Yes No
- (w) Are you under a physician's care?
Yes No
If yes, for what are you being treated?
- (x) Do you have any physical complaints today?
Yes No
If yes, explain:
- (y) Do you have other health conditions not covered by these questions?
Yes No
If yes, explain:

[Statutory Authority: Chapter 49.17 RCW. WSR 88-21-002 (Order 88-23), § 296-62-07548, filed 10/6/88, effective 11/7/88.]