

Cal-OSHA 1529. Asbestos, Appendix D

Medical Questionnaires Mandatory

This mandatory appendix contains the medical questionnaires that must be administered to all employees who are exposed to asbestos above the permissible exposure limit, and who will therefore be included in their employer's medical surveillance program. *Part 1 of the appendix contains the Initial Medical Questionnaire, which must be obtained for all new hires who will be covered by the medical surveillance requirements. Part 2 includes the abbreviated Periodical Medical Questionnaire, which must be administered to all employees who are provided periodic examinations under the medical surveillance provisions of the standard.*

Part 1 INITIAL MEDICAL QUESTIONNAIRE

1. NAME

- 2 SOCIAL
 SECURITY

- 3 CLOCK NUMBER

4. PRESENT OCCUPATION

5. PLANT

6. ADDRESS

7. (Zip Code)

8. TELEPHONE NUMBER

9. INTERVIEWER

- 10 DATE

- 11 DATE OF BIRTH MONTH DAY YEAR

12. Place of Birth

- 13 Sex

1. Male

2. Female

14. What is your marital status?

1. Single

2. Married

3. Widowed

4. Separated/
Divorced

15. Race

1. White

2. Black

3. Asian

4. Hispanic

5. Indian

6. Other

16. What is the highest grade completed in school?

(For example 12 years is completion of high school)

OCCUPATIONAL HISTORY

17A. Have you ever worked full time (30 hours per week or more for 6 months or more?)

1. Yes

2. No

IF YES TO 17A:

B. Have you ever worked for a year or more in any dusty job?

1. Does Not Apply

2. Specify job/industry

3. Total Years Worked

Was dust exposure:

1. Mild ___ 2. Moderate ___ 3. Severe ___

C. Have you even been exposed to gas or

1. Yes

2. No

Chemical fumes in your work?

Specify job/industry:

Total Years Worked:

Was exposure:

1. Mild ___ 2. Moderate ___ 3. Severe ___

D. What has been your usual occupation or job--the one you have worked at the longest?

1. Job occupation

2. Number of years employed in this occupation

3. Position/job title

4. Business, field or industry

(Record on lines the years in which you have worked in any of these industries. e.g. 1960-1969)

19. CHEST COLDS AND CHEST ILLNESSES

19A. If you get a cold, does it usually go to your chest? (Usually means more than 1/2 the time)

1. Yes ___

2. No ___

3. Don't get colds ___

20A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?

1. Yes ___

2. No ___

IF YES TO 20A

B. Did you produce phlegm with any of these chest illnesses?

1. Yes ___

2. No ___

3. Does not apply ___

C. In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more?

Number of illnesses ___

No such illnesses ___

21. Did you have any lung trouble before the age of 16?

1. Yes ___

2. No ___

22. Have you ever had any of the following?

1A. Attacks of bronchitis?

1. Yes ___

2. No ___

IF YES TO 1A:

B. Was it confirmed by a doctor?

1. Yes ___

2. No ___

3. Does Not Apply ___

C. At what age was your first attack?

Age in Years ___

Does Not Apply ___

2A. Pneumonia (include bronchopneumonia)?

1. Yes ___

2. No ___

IF YES TO 2A:

B. Was it confirmed by a doctor?

1. Yes ___

2. No ___

3. Does Not Apply ___

C. At what age did you first have it?

Age in Years ___

Does Not Apply ___

3A. Hay fever?

1. Yes ___

2. No ___

IF YES TO 3A:

B. Was it confirmed by a doctor?

1. Yes ___

2. No ___

3. Does Not Apply ___

C. At what age did it start?

Age in Years ___

Does Not Apply ___

23A. Have you ever had chronic bronchitis?

1. Yes ___

2. No ___

IF YES TO 23A:

B. Do you still have it?

1. Yes ___

2. No ___

3. Does Not Apply ___

C. Was it confirmed by a doctor?

1. Yes ___

2. No ___

3. Does Not Apply ___

D. At what age did it start?

Age in Years ___

Does Not Apply ___

24A. Have you ever had emphysema?

1. Yes ___

2. No ___

IF YES TO 24A:

B. Do you still have it?

1. Yes ___

2. No ___

3. Does Not Apply ___

C. Was it confirmed by a doctor?

1. Yes ___

2. No ___

3. Does Not Apply ___

D. At what age did it start?

Age in Years ___

Does Not Apply ___

25A. Have you ever had asthma?

1. Yes ___

2. No ___

IF YES TO 25A:

B. Do you still have it?

1. Yes ___

2. No ___

3. Does Not Apply ___

C. Was it confirmed by a doctor?

1. Yes ___

2. No ___

3. Does Not Apply ___

D. At what age did it start?

Age in Years ___

Does Not Apply ___

E. If you no longer have it, at what age did it stop?

Age stopped ___

Does Not Apply ___

26. Have you ever had:

A. Any other chest illness?

1. Yes ___

2. No ___

If yes, please specify

B. Any chest operations?

1. Yes ___

2. No ___

If yes, please specify

C. Any chest injuries?

1. Yes ___

2. No ___

If yes, please specify

27A. Has a doctor ever told you that you had heart trouble?

1. Yes ___

2. No ___

IF YES TO 27A:

B. Have you ever had treatment for heart trouble in the past 10 years?

1. Yes ___

2. No ___

3. Does not apply ___

28A. Has a doctor ever told you that you had high blood pressure?

1. Yes ___

2. No ___

IF YES TO 28A:

B. Have you ever had treatment for high blood pressure (hypertension) in the past 10 years?

1. Yes ___
2. No ___
3. Does not apply ___

29. When did you last have your chest X-rayed?(Year)

(Year)

Where did you last have your chest X-rayed (if known)?

What was the outcome?

FAMILY HISTORY

31. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

FATHER

1. Yes
2. No
3. Don't Know

MOTHER

1. Yes
2. No
3. Don't Know

A. Chronic Bronchitis?

B. Emphysema?

C. Asthma?

D. Lung cancer?

E. Other chest conditions?

F. Is parent currently alive?

G. Please Specify

Age if Living:

Age at Death:

Don't Know _____

Age if Living:
Age at Death:
Don't Know_____

H. Please specify cause of death:

COUGH 32A.

Do you usually have a cough? (Count a cough with first smoke or on first going out doors. Exclude clearing of throat) [If no, skip to question 32C.]

1. Yes ___

2. No___

B. Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week?

Yes ___

2. No___

C. Do you usually cough at all on getting up or first thing in the morning?

1. Yes ___

2. No___

D. Do you usually cough at all during the rest of the day or at night?

1. Yes ___

2. No___

IF YES TO ANY OF ABOVE (32A, B, C, OR D), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK DOES NOT APPLY AND SKIP TO NEXT PAGE.

E. Do you usually cough like this on most days for 3 consecutive months or more during the year?

1. Yes ___

2. No___

3. Does not apply___

F. For how many years have you had the cough?

Number of Years___

Does Not Apply___

33A. Do you usually bring up phlegm from your chest?

(Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) (If no, skip to 33C)

1. Yes ___

2. No___

B. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week?

- 1. Yes ___
- 2. No ___

C. Do you usually bring up phlegm at all on getting up or first thing in the morning?

- 1. Yes ___
- 2. No ___

D. Do you usually bring up phlegm at all during the rest of the day or at night?

- 1. Yes ___
- 2. No ___

IF YES TO ANY OF THE ABOVE (33A, B, C, OR D), ANSWER THE FOLLOWING: IF NO TO ALL, CHECK DOES NOT APPLY AND SKIP TO 34A.

E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?

- 1. Yes ___
- 2. No ___
- 3. Does not apply ___

F. For how many years have you had trouble with phlegm?

- Number of years ___
- Does not apply ___

EPISODES OF COUGH AND PHLEGM

34A. Have you had periods or episodes of (increased*) and phlegm lasting for 3 weeks or more each year?

*(For persons who usually have cough and/or phlegm

-)1. Yes ___
- 2. No ___

IF YES TO 34A

B. For how long have you had at least 1 such episode per year?

- Number of years ___
- Does not apply ___

WHEEZING

35A. Does your chest ever sound wheezy or whistling

1. When you have a cold?

- 1. Yes ___
- 2. No ___

2. Occasionally apart from colds?

1. Yes ___

2. No ___

3. Most days or nights?

1. Yes ___

2. No ___

IF YES TO 1, 2, or 3 in 35A

B. For how many years has this been present?

Number of years ___

Does not apply ___

36A. Have you ever had an attack of wheezing that has made you feel short of breath?

1. Yes ___

2. No ___

B. How old were you when you had your first such attack?

Age in years ___

Does not apply ___

C. Have you had 2 or more such episodes?

1. Yes ___

2. No ___

3. Does not apply ___

D. Have you ever required medicine or treatment for the(se) attack(s)?

1. Yes ___

2. No ___

3. Does not apply ___

BREATHLESSNESS

37. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 39A.

Nature of condition(s)

38A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

1. Yes ___

2. No ___

IF YES TO 38A

B. Do you have a walk slower than people of your age on the level because of breathlessness?

1. Yes ___
2. No___
3. Does not apply___

C. Do you ever have to stop for breath when walking at your own pace on the level?

1. Yes ___
2. No___
3. Does not apply___

D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?

1. Yes ___
2. No___
3. Does not apply___

E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs?

1. Yes ___
2. No___
3. Does not apply___

TOBACCO SMOKING

39A. Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year.)

1. Yes ___
2. No___

IF YES TO 39A

B. Do you now smoke cigarettes (as of one month ago)

1. Yes ___
2. No___
3. Does not apply___

C. How old were you when you first started regular cigarette smoking?

Age in years___
Does not apply___

D. If you have stopped smoking cigarettes completely, how old were you when you stopped?

Age stopped___
Check if still smoking___
Does not apply___

E. How many cigarettes do you smoke per day now?

Cigarettes per day__

Does not apply__

F. On the average of the entire time you smoked, how many cigarettes did you smoke per day?

Cigarettes per day__

Does not apply__

G. Do or did you inhale the cigarette smoke?

1.Does not apply__

2.Not at all__

3.Slightly__

4.Moderately__

5.Deeply__

40A. Have you ever smoked a pipe regularly?

(Yes means more than 12 oz. of tobacco in a lifetime.)

1. Yes __

2. No__

IF YES TO 40A:

B. 1. How old were you when you started to smoke a pipe regularly?

Age__

2. If you have stopped smoking a pipe completely, how old were you when you stopped?

Age stopped__

Check of still smoking pipe__

Does not apply__

C. On the average over the entire time you smoked a pipe how much pipe tobacco did you smoke per week?

(a standard pouch of tobacco contains 1 1/2 oz.)

oz. per week__

Does not apply__

D. How much pipe tobacco are you smoking now?

oz. per week__

Not currently smoking a pipe__

E. Do you or did you inhale the pipe smoke?

1.Never smoked__

2.Not at all__

3.Slightly__

4.Moderately__

5.Deeply__

41A. Have you ever smoked cigars regularly? (Yes means more than 1 cigar a week for a year)

1. Yes ___

2. No ___

IF YES TO 41A

FOR PERSONS WHO HAVE EVER SMOKED CIGARS

B. 1. How old were you when you started smoking cigars regularly?

Age ___

2. If you have stopped smoking cigars completely, how old were you when you stopped?

Age stopped ___

Check if still smoking cigars ___

Does not apply ___

C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week?

Cigars per week ___

Does not apply ___

D. How many cigars are you smoking per week now?

Cigars per week ___

Check if not smoking cigars currently ___

E. Do or did you inhale the cigar smoke?

1. Never smoked ___

2. Not at all ___

3. Slightly ___

4. Moderately ___

5. Deeply ___

Signature

Date

Part 2

PERIODIC MEDICAL QUESTIONNAIRE

1. NAME

2 SOCIAL
SECURITY

3 CLOCK NUMBER

4. PRESENT OCCUPATION

5. PLANT

6. ADDRESS

7. (Zip Code)

8. TELEPHONE NUMBER

9. INTERVIEWER

10 DATE

12. OCCUPATIONAL HISTORY

12A. Have you ever worked full time (30 hours per week or more for 6 months or more?)

1. Yes
2. No

IF YES TO 12A:

12B. Have you ever worked for a year or more in any dusty job?

1. Does Not Apply
2. Specify job/industry
3. Total Years Worked

12C. Was dust exposure:

1. Mild ___
2. Moderate ___
3. Severe ___

12D. In the past year, were you exposed to gas or chemical fumes in your work?

1. Yes ___

2. No ___

12E. Was exposure:

1. Mild ___ 2. Moderate ___ 3. Severe ___

12F. In the past year, what was your

1. Job/occupation?

2. Position/job title?

13. RECENT MEDICAL HISTORY

13A. Do you consider yourself to be in good health?

Yes ___

No ___

IF NO, state reason

13B. In the past year, have you developed:

Epilepsy?

Yes ___

No ___

Rheumatic fever?

Yes ___

No ___

Kidney disease?

Yes ___

No ___

Bladder disease?

Yes ___

No ___

Diabetes?

Yes ___

No ___

Jaundice?

Yes ___

No ___

Cancer?

Yes___

No___

14. CHEST COLDS AND CHEST ILLNESSES

14A. If you get a cold, does it usually go to your chest? (Usually means more than 1/2 the time)

1. Yes ___

2 No. ___

3. Don't get colds___

15A. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?

1. Yes ___

2 No. ___

3. Does Not Apply___

IF YES TO 15A:

15B. Did you produce phlegm with any of these chest illnesses?

1. Yes ___

2 No. ___

3. Does Not Apply___

15C. In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more?

Number of illnesses___

No such illnesses___

16. RESPIRATORY SYSTEM

In the past year have you had:

Yes or No

Further Comment on Positive Answers

Asthma _____

Bronchitis _____

Hay Fever _____

Other Allergies _____

Yes or No

Further Comment on Positive Answers

Pneumonia _____

Tuberculosis _____

Chest Surgery _____
Other Lung Problems _____
Heart Disease _____

Do you have:

Yes or No
Further Comment on Positive Answers

Frequent colds _____
Chronic cough _____
Shortness of breath when walking or climbing one flight of stairs _____

Do you:

Wheeze _____
Cough up phlegm _____
Smoke cigarettes _____
Packs per day _____
How many years _____

Signature

Date

NOTE

Authority cited: Section 142.3, Labor Code. Reference: Section 142.3, Labor Code.

HISTORY

1. New Appendix D to section 1529 filed 2-15-91; operative 2-15-91 pursuant to Government Code section 11346(d) (Register 91, No. 19).
2. Editorial correction of HISTORY 1. (Register 91, No. 45).
3. Amendment of appendix and Note filed 5-3-96; operative 7-3-96 (Register 96, No. 18).
4. Editorial correction of Part 1, No. 16 (Register 99, No. 28).