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 medical examinations under the medical surveillance provisions of the standard.

**APPENDIX D TO §1910.1001—MEDICAL QUESTIONNAIRES; MANDATORY**

Under the asbestos in general industry standard, this medical questionnaire 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. (29 CFR 1910.1001(l)(2)(ii)). According to the Paperwork Reduction Act, an Agency may not conduct or sponsor, and no persons are required to respond to, a collection of information unless such collection displays a valid OMB control number. Use of this questionnaire is mandatory. The questionnaire assists both physicians and employers to ensure that the physician obtains compliant employee medical documentation. OSHA estimates employer burden for the completion of this collection of information is 2 hours and 20 minutes (2.33 hours). This estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and, completing and reviewing the collection of information. The time estimate includes employer time for compliance with the underlying collections of information in 29 CFR 1910.1001(l), including employee time for completion of the questionnaire and medical examination, providing information to the physician, and maintaining employee medical records. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to OSHAPRA@dol.gov or to OSHA’s Directorate of Standards and Guidance, Department of Labor, Room N-3718, 200 Constitution Ave., NW, Washington, DC; 20210; Attn: Paperwork Reduction Act Comment. (This address is for comments regarding this form only; **DO NOT SEND ANY COMPLETED SAMPLE FORM TO THIS OFFICE.**)

**OMB Approval# 1218-0133; Expires: 00-00-0000**
Part 1
INITIAL MEDICAL QUESTIONNAIRE

1. NAME ________________________________

2. SOCIAL SECURITY #
   1  2  3  4  5  6  7  8  9

3. CLOCK NUMBER
   10  11  12  13  14  15

4. PRESENT OCCUPATION ________________________________

5. PLANT ________________________________

6. ADDRESS ________________________________

7. ________________________________ (Zip Code)

8. TELEPHONE NUMBER ________________________________

9. INTERVIEWER ________________________________

10. DATE ________________________________ 16  17  18  19  20  21

11. Date of Birth ________________________________
    Month  Day  Year  22  23  24  25  26  27

12. Place of Birth ________________________________

13. Sex
    1. Male ___
    2. Female ___

    2. Married ___  Divorced ___
    3. Widowed ___

15. Race
    1. White ___ 4. Hispanic ___
    2. Black ___ 5. Indian ___
    3. Asian ___ 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. Yes ___ 2. No ___ 3. Does Not Apply ___
Specify job/industry __________________________  Total Years Worked __


C. Have you even been exposed to gas or chemical fumes in your work?
   Specify job/industry __________________________  Total Years Worked __


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)

Have you ever worked:

   E. In a mine?.................................. [___] [___]
   F. In a quarry?.................................. [___] [___]
   G. In a foundry?............................ [___] [___]
   H. In a pottery?.................................. [___] [___]
   I. In a cotton, flax or hemp mill?......... [___] [___]
   J. With asbestos?........................... [___] [___]

18. PAST MEDICAL HISTORY

   YES NO

   A. Do you consider yourself to be in good health? [___] [___]

      If "NO" state reason ________________________________

   B. Have you any defect of vision?............... [___] [___]

      If "YES" state nature of defect ________________________________

   C. Have you any hearing defect?............... [___] [___]

      If "YES" state nature of defect ________________________________
D. Are you suffering from or have you ever suffered from:
   a. Epilepsy (or fits, seizures, convulsions)?  [___]  [___]
   b. Rheumatic fever?  [___]  [___]
   c. Kidney disease?  [___]  [___]
   d. Bladder disease?  [___]  [___]
   e. Diabetes?  [___]  [___]
   f. Jaundice?  [___]  [___]

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?
   IF YES TO 3A:
   B. Was it confirmed by a doctor?

   C. At what age did it start?

23A. Have you ever had chronic bronchitis?
   IF YES TO 23A:
   B. Do you still have it?

   C. Was it confirmed by a doctor?

   D. At what age did it start?

24A. Have you ever had emphysema?
   IF YES TO 24A:
   B. Do you still have it?

   C. Was it confirmed by a doctor?

   D. At what age did it start?

25A. Have you ever had asthma?
   IF YES TO 25A:
   B. Do you still have it?

   C. Was it confirmed by a doctor?

   D. At what age did it start?

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

26. Have you ever had:
   A. Any other chest illness?

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 __  
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 had any 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)  
25 26 27 28

30. 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:

<table>
<thead>
<tr>
<th>Condition</th>
<th>FATHER</th>
<th>MOTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Chronic Bronchitis?</td>
<td>1. Yes</td>
<td>1. Yes</td>
</tr>
<tr>
<td>B. Emphysema?</td>
<td>2. No</td>
<td>2. No</td>
</tr>
<tr>
<td>C. Asthma?</td>
<td>3. Don't Know</td>
<td>3. Don't Know</td>
</tr>
<tr>
<td>D. Lung cancer?</td>
<td>1. Yes</td>
<td>1. Yes</td>
</tr>
<tr>
<td>E. Other chest conditions</td>
<td>2. No</td>
<td>2. No</td>
</tr>
<tr>
<td>F. Is parent currently alive?</td>
<td>3. Don't Know</td>
<td>3. Don't Know</td>
</tr>
</tbody>
</table>

G. Please Specify  
__ 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 of 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?

1. 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*) cough 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?

2. Occasionally apart from colds?

3. Most days or nights?

1. Yes __  2. No __

1. Yes __  2. No __

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 __

IF YES TO 36A

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 __

BREATHELESSNESS

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 to 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?  

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:
FOR PERSONS WHO HAVE EVER SMOKED A PIPE

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

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

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

D. How much pipe tobacco are you smoking now?

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

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

IF YES TO 41A
FOR PERSONS WHO HAVE EVER SMOKED CIGARS

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

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

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

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

E. Do or did you inhale the cigar smoke?

Signature ___________________________ Date ___________________________
Part 2
PERIODIC MEDICAL QUESTIONNAIRE

1. NAME ____________________________

2. SOCIAL SECURITY # 1 2 3 4 5 6 7 8 9 ___

3. CLOCK NUMBER 10 11 12 13 14 15 ___

4. PRESENT OCCUPATION ____________________________

5. PLANT ____________________________

6. ADDRESS ____________________________

7. ____________________________ (Zip Code)

8. TELEPHONE NUMBER ____________________________

9. INTERVIEWER ____________________________

10. DATE ____________________________ 16 17 18 19 20 21 ___


12. OCCUPATIONAL HISTORY

12A. In the past year, did you work full time (30 hours per week or more) for 6 months or more? 1. Yes ___ 2. No ___

IF YES TO 12A:

12B. In the past year, did you work in a dusty job? 1. Yes ___ 2. No ___ 3. Does Not Apply ___


12D. In the past year, were you exposed to gas or chemical fumes in your work? 1. Yes ___ 2. No ___


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:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic fever?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bladder disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jaundice?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes or No</th>
<th>Further Comment on Positive Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hay Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Allergies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Pneumonia
Tuberculosis
Chest Surgery
Other Lung Problems
Heart Disease

Do you have:

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

Do you:
Wheeze
Cough up phlegm
Smoke cigarettes

Date ________________  Signature _________________________

Packs per day ___  How many years ___