

GENERAL TOXICOLOGY QUESTIONNAIRE

HAZ-MAT QUESTIONNAIRE

Page 1 **HEALTH AND EXPOSURE HISTORY**

PLEASE SELECT THE BEST ANSWER FOR EACH QUESTION. PLEASE USE A PEN TO FILL OUT THE QUESTIONNAIRE. WRITE CLEARLY.

Date Completed: / /	Employee #:	Social Security #: - -
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Name: First	Last	Middle
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Home Address: Street	Apt #	Home Phone: ()
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City:	State:	Zip:
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Sex: <input type="checkbox"/> Male(M) <input type="checkbox"/> Female(F)	Age:	Date of Birth: / /	Place of Birth (City, State):
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Race	<input type="checkbox"/> White (W) <input type="checkbox"/> Black (B) <input type="checkbox"/> Hispanic (H) <input type="checkbox"/> Native American (I) <input type="checkbox"/> Other (O)
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Marital Status	<input type="checkbox"/> Never Married (N) <input type="checkbox"/> Married (M) <input type="checkbox"/> Widowed (W) <input type="checkbox"/> Divorced (D) <input type="checkbox"/> Separated (S)
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Jobs you have had in the last 10-20 years... (Please list the most recent job first)

<u>Year(s)</u>	<u>Job Title or Task</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Last Year of Education Completed: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	11	12	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	13	14	15	16	<input type="checkbox"/>	17	<input type="checkbox"/>	18
	Primary Grades												College				Masters		Doctorate		

Closest Living Relative	Name:	Relationship:	Phone: ()
	Address:	Street	Apt #
	City:	State:	Zip:

Personal Physician	Name:	Phone: ()
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General Toxicology Questionnaire

Page 2

Health Status: Excellent (E) Very Good (V) Good (G) Fair (F) Poor (P)

Statement of Your Present Health in Your Own Words:

Do you have any work-related health changes? Yes No If yes, please explain.

Have you ever had any illness which has left you with a physical or health problem? Yes No
If yes, please explain.

Has a doctor ever restricted your work or physical activities for medical reasons? Yes No
If yes, please explain.

Have you had any operation or surgery? Yes No If yes, state reason for surgery, type of operation and date. (use space at bottom of page if more room is required)

When you do chores around your house/yard, do you use chemicals such as pesticides, herbicides, etc? Yes No If yes, please explain.

How often do you eat fruits & vegetables?

Daily (D) 3-5 Times Week (3) 1-2 Times Week (1) 1-2 Times Month (M) Never (N)

Signature: _____ **Date:** _____

The information on this form is for medical use only and will not be released to unauthorized personnel.

EXPOSURE HISTORY

Enter the number of YEARS EXPOSURE under the appropriate column for each material you worked with or were exposed to.

Chemicals	Work Before Present Job	Work at Present Job	Other
Acrylimide	_____	_____	_____
Acetone	_____	_____	_____
Alcohol	_____	_____	_____
Ammonia	_____	_____	_____
Benzo(a)pyrine	_____	_____	_____
Benzene	_____	_____	_____
Benzidene	_____	_____	_____
1, 3 Butadiene	_____	_____	_____
Carbon Disulfide	_____	_____	_____
Carbon Monoxide	_____	_____	_____
Chloroform	_____	_____	_____
Ethylene Oxide	_____	_____	_____
Chlorine	_____	_____	_____
Chromic Acid Mist	_____	_____	_____
Cutting Oils	_____	_____	_____
Cyanide	_____	_____	_____
Cyclohexane	_____	_____	_____
Ethyl Alcohol	_____	_____	_____
Freon	_____	_____	_____
Graphite	_____	_____	_____
Hydrogen Fluoride	_____	_____	_____
Hydrazine	_____	_____	_____
Hydrochloric Acid	_____	_____	_____
Hydrogen Peroxide	_____	_____	_____
Isocyanates	_____	_____	_____
Isopropyl Alcohol	_____	_____	_____
Fluorides	_____	_____	_____
Formaldehyde	_____	_____	_____
Nitric Acid	_____	_____	_____
Methyl Alcohol	_____	_____	_____
Methylene Chloride	_____	_____	_____
Methylene Dianiline	_____	_____	_____
Potassium Chromate	_____	_____	_____
Polychlorinated	_____	_____	_____
Biphenyls (PCB's)	_____	_____	_____
Pesticides	_____	_____	_____
Phenols	_____	_____	_____
Phosgene	_____	_____	_____
Plastics	_____	_____	_____
Propylene Oxide	_____	_____	_____
Perchloroethylene	_____	_____	_____
Tetrabromoethylene	_____	_____	_____
Trichloroethylene	_____	_____	_____
Trichloroethane	_____	_____	_____
Toluene	_____	_____	_____
Uranyl Nitrate	_____	_____	_____
Vinyl Chloride	_____	_____	_____
Xylene	_____	_____	_____

EXPOSURE HISTORY

Paints/Adhesives		Work Before Present Job	Work at Present Job	Other
301	Epoxy Resins	_____	_____	_____
302	Glues	_____	_____	_____
303	Paints (spray)	_____	_____	_____
304	Roofing Material	_____	_____	_____
305	Solvents	_____	_____	_____
306	Turpentine	_____	_____	_____
Metals				
401	Ammunition Loading	_____	_____	_____
402	Antimony	_____	_____	_____
403	Arsenic	_____	_____	_____
404	Beryllium	_____	_____	_____
405	Cadmium	_____	_____	_____
406	Chromium (Chromates)	_____	_____	_____
407	Cobalt	_____	_____	_____
408	Lead	_____	_____	_____
409	Mercury	_____	_____	_____
410	Nickel	_____	_____	_____
411	Stainless Steel	_____	_____	_____
412	Titanium	_____	_____	_____
413	Welding Fumes	_____	_____	_____
414	Zinc	_____	_____	_____
Radiation				
501	Microwave	_____	_____	_____
502	Laser	_____	_____	_____
503	Americium	_____	_____	_____
504	Plutonium	_____	_____	_____
505	Thorium	_____	_____	_____
506	Tritium	_____	_____	_____
507	Uranium	_____	_____	_____
508	Radio Frequency	_____	_____	_____
509	X-Ray	_____	_____	_____
510	Electromagnetic	_____	_____	_____
Dusts/Particles				
601	Asbestos	_____	_____	_____
602	Ceramic Fibers	_____	_____	_____
603	Coal	_____	_____	_____
604	Fiberglass	_____	_____	_____
605	Sandblasting	_____	_____	_____
Other Hazards				
701	Loud Noise	_____	_____	_____
702	Loud Impact Noise	_____	_____	_____
703	Heat	_____	_____	_____
704	Cold	_____	_____	_____
705	Heights	_____	_____	_____
706	Vibration	_____	_____	_____
801	Other (list Below)			
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PERSONAL HEALTH HISTORY

HEALTH HISTORY										Please CIRCLE the appropriate responses and provide the year diagnosed.									
				Year						Year									
Do you or Have you had?	Yes	No	Unsure	Diag.	Do you or Have you had?	Yes	No	Unsure	Diag.										
1 Asthma	Y	N	U	_____	34 Frequent/Severe Headaches	Y	N	U	_____										
2 Allergies	Y	N	U	_____	35 Depression or Anxiety	Y	N	U	_____										
3 Bronchitis	Y	N	U	_____	36 Nervousness	Y	N	U	_____										
4 Emphysema	Y	N	U	_____	37 Frequent Fatigue/ Tiredness	Y	N	U	_____										
5 Shortness of Breath	Y	N	U	_____	38 Nausea	Y	N	U	_____										
6 Heart Disease or Attack	Y	N	U	_____	39 Numbness (Hands, Limbs, Feet)	Y	N	U	_____										
7 High Blood Pressure	Y	N	U	_____	40 Paralysis (Hands, Limbs, Feet)	Y	N	U	_____										
8 Anemia/Blood Disorder	Y	N	U	_____	41 Weakness (Hands, Limbs, Feet)	Y	N	U	_____										
9 Cough	Y	N	U	_____	42 Alcohol/Drug Problems	Y	N	U	_____										
10 Cough up Blood	Y	N	U	_____	43 Speech Impairment	Y	N	U	_____										
11 Hay Fever	Y	N	U	_____	44 Vision Impairment	Y	N	U	_____										
12 Lung Problems	Y	N	U	_____	45 Hearing Impairment	Y	N	U	_____										
13 Pneumonia	Y	N	U	_____	46 Arthritis	Y	N	U	_____										
14 Tuberculosis	Y	N	U	_____	47 Rheumatism	Y	N	U	_____										
15 COPD (Chronic Obstructive Pulmonary Disease)	Y	N	U	_____	48 Joint Disorders	Y	N	U	_____										
16 Kidney Disease	Y	N	U	_____	49 Chronic Back Pain	Y	N	U	_____										
17 Prostate Problems (Not Cancer)	Y	N	U	_____	50 Chronic Neck Pain	Y	N	U	_____										
18 Urinary Tract Disorders	Y	N	U	_____	51 Skin Disease	Y	N	U	_____										
19 Cirrhosis of Liver	Y	N	U	_____	52 Skin Rash/Allergies	Y	N	U	_____										
20 Liver Disease	Y	N	U	_____	53 Skin Sensitivities	Y	N	U	_____										
21 Hepatitis	Y	N	U	_____	54 Sterility or Infertility	Y	N	U	_____										
22 Stomach Problems	Y	N	U	_____	55 Miscarriage(s)	Y	N	U	_____										
23 Ulcers	Y	N	U	_____	56 Spontaneous Abortion(s)	Y	N	U	_____										
24 Gall Bladder Problems	Y	N	U	_____	57 Child with Birth Defects	Y	N	U	_____										
25 Intestinal Problems	Y	N	U	_____	58 Birth Defects (Self)	Y	N	U	_____										
26 Diabetes	Y	N	U	_____	59 Disabilities	Y	N	U	_____										
27 Epilepsy	Y	N	U	_____	60 Cancer	Y	N	U	_____										
28 Muscular Dystrophy	Y	N	U	_____	61 Leukemia	Y	N	U	_____										
29 Parkinson's Disease	Y	N	U	_____	62 Skin Cancer	Y	N	U	_____										
30 Seizures	Y	N	U	_____	63 Prostate Cancer	Y	N	U	_____										
31 Stroke	Y	N	U	_____															
32 Senile Dementia/ Alzheimer's	Y	N	U	_____															
33 Tremors	Y	N	U	_____															
Other Conditions (specify):	_____				If other cancer, specify type and location:	_____													

Do you have any disabilities, either congenital (born with) or other? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain:
Do you have, or have you had any chronic or serious illnesses or surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain:

**HEALTH and EXPOSURE HISTORY
Health Surveillance Program**

PLEASE SELECT THE BEST ANSWER FOR EACH QUESTION. PLEASE USE A PEN TO FILL OUT THE QUESTIONNAIRE. WRITE CLEARLY.

Name: First Last Middle

CURRENT EMPLOYEES PLEASE FILL IN EXTENSION, DEPARTMENT, AND BUILDING

Extension: Department: Building:

EVERYONE PLEASE FILL IN THE FOLLOWING INFORMATION

While at your work place, did you ever work with beryllium? Yes No

While at your work place, did you ever feel you were ever exposed to beryllium? Yes No

During which years did you work with or do you feel you were exposed to beryllium? 19__ to 19__

Did you ever work:

 In a mine? Yes No Year Started _____ Year Ended _____

 In a quarry? Yes No Year Started _____ Year Ended _____

 In a foundry? Yes No Year Started _____ Year Ended _____

 In a pottery? Yes No Year Started _____ Year Ended _____

 With asbestos? Yes No Year Started _____ Year Ended _____

 In a cotton, flax or hemp mill? Yes No Year Started _____ Year Ended _____

Please CIRCLE the appropriate response if you had any of the following conditions. Please provide the year diagnosed.

	Yes	No	Year Diag
Except when you have a cold (influenza), have you ever had an attack of wheezing that made you feel short of breath?	Y	N	
Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?	Y	N	
Do you ever have to stop to catch your breath when walking at your own pace on level ground?	Y	N	
Do you have to walk slower than people of your age on level ground because of breathlessness?	Y	N	
Are you presently taking any prescription medication for pulmonary (lung) problems? If yes, please list:	Y	N	

Signature: _____ Date: _____

The information on this form is for medical use only and will not be released to unauthorized personnel.

For Office Use Only

Comments:

PERSONAL PROTECTIVE EQUIPMENT

Did you or are you now required to use any of the following:

Noise	<u>Please Check the Appropriate Box</u>		<u>Date or Year</u>
Ear Plugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Ear Muffs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Radiation			
Dosimeter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Film Badge	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Gloves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Protective Clothing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Chemical Exposures			
Gloves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Protective Clothing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Respirator	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Respirator Use			
½ Face	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Full Face	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Supplied Air	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
SCBA	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

FAMILY HISTORY

FAMILY HISTORY

Please CIRCLE the appropriate response for each medical condition that anyone in your family has/had.

	Father or Father's Family	Mother or Mother's Family	Brother or Sister	Not Known
Cancer	F	M	B-S	U
Neurological Disease (Stroke, Epilepsy, Alzheimer's, Etc.)	F	M	B-S	U
Psychological Problems (Nervous Breakdown, Depression, etc)	F	M	B-S	U
Respiratory Disease	F	M	B-S	U
Heart Disease	F	M	B-S	U
Kidney Disease	F	M	B-S	U
Metabolic Disease (diabetes, Thyroid, etc)	F	M	B-S	U
Gastrointestinal Disease (Ulcers, etc)	F	M	B-S	U
Musculo-Skeletal Disease (Arthritis, etc)	F	M	B-S	U
Impairments (Speech, Vision, Hearing)	F	M	B-S	U
Reproductive Problems	F	M	B-S	U
Birth Defects	F	M	B-S	U
Immunological Problems	F	M	B-S	U
Alcohol Consumption	F	M	B-S	U
Tobacco Use (Smoking, Chewing)	F	M	B-S	U
Other:	F	M	B-S	U

Comments: (Please feel free to enter any comments in this space.)

ADDITIONAL INFORMATION

Have you ever smoked? Yes No
 ("NO" means less than 20 packs in a lifetime or less than 1 cigarette a day for a year.)

How old were you when you first started regular cigarette smoking? If you stopped smoking cigarettes, how old were you when you quit?

Do you now smoke cigarettes? (In the past month) Yes No

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

Do you, or did you inhale the cigarette smoke? Not at All (N) Slightly (S) Moderately (M) Deeply (D)

Have you ever smoked cigars regularly? Yes No
 ("YES" means more than 1 cigar a week for 1 year.)

How old were you when you first started regular cigar smoking? If you stopped smoking cigars, how old were you when you quit?

Do you now smoke cigars? Yes No

How many cigars do you now smoke per day? On the average, of the entire time you smoked, how many cigars did you smoke per day?

Do you, or did you inhale the cigar smoke? Not at All (N) Slightly (S) Moderately (M) Deeply (D)

Have you ever smoked a pipe? Currently (C) Past (P) Never (N)
 Pipe (P) Years Smoked _____
 Ounces/Day (Circle one) 1 or less 2 3 4 5 6 7 8 9 10 or more

Have you ever chewed tobacco? Currently (C) Past (P) Never (N)
 Chewed (C) Years Chewed _____
 Tins/Week (Circle one) 1 or less 2 3 4 5 6 7 8 9 10 or more

Have you ever been exposed to other people's tobacco smoke (passive smoking)? Yes No

At home by your parents?	Yes	No	If yes, number of years: _____
At home by your spouse(s)?	Yes	No	If yes, number of years: _____
At home by others?	Yes	No	If yes, number of years: _____
At work?	Yes	No	If yes, number of years: _____
In social situations?	Yes	No	If yes, number of years: _____
In the community?	Yes	No	If yes, number of years: _____

Alcoholic consumption Currently (C) Past (P) Never (N) Occasionally (O)

Beer	Number of years: _____	(Average bottles/week)	1 or less	2	3	4	5	6	7	8	9	10	or more
Wine	Number of years: _____	(Average glasses/week)	1 or less	2	3	4	5	6	7	8	9	10	or more
Liquor	Number of years: _____	(Average ounces/week)	1 or less	2	3	4	5	6	7	8	9	10	or more

If male, how many pregnancies have you fathered?

If female, how many pregnancies have you had?

How many living children do you have?

Have you fathered or conceived children from more than one marriage? Yes No
 If YES, how many children from each?

How many miscarriages have you had or has your wife (or wives) had?

How many children with birth defects have you had?
 If you have children with birth defects, please give dates of birth:

Comments: