FORMALDEHYDE MEDICAL DISEASE QUESTIONNAIRE

This questionnaire will be used for all employees prior to assignment to a job where a formaldehyde exposure is at or above the action level or the STEL or when an employee experiences signs and symptoms indicative of possible overexposure to formaldehyde. All medical information is considered confidential.

Name:			**ID/SSN: XXX-XX-**	
DOB: / /	**Sex: M / F**	**Age:**	**Height:**	**Weight:**
Are you: IU Employee____ MD____ IUSOM Faculty____ Resident/Fellow_____ Student_____				
Department:	**Manager:**		**Job Title:**	
How best to reach you:	**Best time to call:**		**Phone/Pager:**	

Medical History

Please check the appropriate box below	**NO**	**YES**
1. Have you ever been in the hospital as a patient? If "Yes", what kind of problem were you having? _____		
2. Have you ever had any kind of operation? If "Yes", what kind? _____		
3. Do you take any kind of medicine regularly? If "Yes", what kind? _____		
4. Are you allergic to any drugs, foods, or chemicals? If yes, what kind of allergy is it? _____ What causes the allergy? _____		
5. Have you ever been told that you have asthma, hayfever, or sinusitis?		
6. Have you ever been told that you have emphysema, bronchitis, or any other respiratory problems?		
7. Have you ever been told that you have hepatitis?		
8. Have you ever been told that you have cirrhosis?		
9. Have you ever been told that you have cancer?		
10. Have you ever had arthritis or joint pain?		
11. Have you ever been told that you had high blood pressure?		
12. Have you ever had a heart attack or heart trouble?		

Medical History Update

Please check the appropriate box below	**NO**	**YES**
1. Have you been in the hospital as a patient any time within the past year? If so, for what condition? _____		
2. Have you been under the care of a physician during the past year? If so, for what condition? _____		
3. Is there any change in your breathing since last year? (check what applies) ☐ Better ☐ Worse ☐ No change If change, do you know why? _____		
4. Is your general health different this year from last year?		
5. Have you in the past year or are you now taking any medication on a regular basis? Name Rx_____ Condition being treated _____		

Occupational History		
1. How long have you worked for your present employer? Years - Months -		
2. What jobs have you held with this employer? Include job title and length of time in each job.		
3. In each of these jobs, how many hours a day were you exposed to chemicals?		
4. What chemicals have you worked with most of the time?		
Please check the appropriate box below	**NO**	**YES**
5. Have you ever noticed any type of skin rash you feel was related to your work?		
6. Have you ever noticed that any kind of chemical makes you cough?		
7. Have you ever noticed that any kind of chemical makes you wheeze?		
8. Have you ever noticed that any kind of chemical makes you become short of breath or cause your chest to become tight?		
9. Are you exposed to any dust or chemicals at home? If yes, explain:_____		
10. In other jobs, have you ever had exposure to:		
a. Wood Dust		
b. Nickel or Chromium		
c. Silica (foundry, sand blasting)		
d. Arsenic or Asbestos		
e. Organic Solvents		
f. Urethane Foams		

Occupational History Update		
Please check the appropriate box below	**NO**	**YES**
1. Are you working on the same job this year as you were last year? If not, how has your job changed? _____ _____ _____		
2. Have you noticed any skin rash within the past year you feel was related to your work? If so, explain circumstances:_____ _____ _____		
3. Have you noticed that any chemical makes you cough, be short of breath, or wheeze? If so, can you identify it? _____ _____ _____		
4. What chemicals are you exposed to on your job?		

Miscellaneous

Please check the appropriate box below	**NO**	**YES**
1. Do you smoke? (check all that apply)		
☐ Pipe How much? For how long?		
☐ Cigars How much? For how long?		
☐ Cigarettes How much? For how long?		
2. Do you drink alcohol in any form? If so, how much, how long, and how often?		
3. Do you wear glasses or contact lenses?		
4. Do you get any physical exercise other than that required to do your job? If so, explain:_____		
5. 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.? If so, please describe, giving type of business or hobby, chemicals used and length of exposures.		

Symptoms Questionnaire

Please check the appropriate box below	**NO**	**YES**
1. Do you ever have any shortness of breath?		
a. If yes, do you have to rest after climbing several flights of stairs?		
b. If yes, if you walk on the level with people your own age, do you walk slower than they do?		
c. If yes, if you walk slower than a normal pace, do you have to limit the distance that you walk?		
d. If yes, do you have to stop and rest while bathing or dressing?		
2. Do you cough as much as three months out of the year?		
a. If yes, have you had this cough for more than two years?		
b. If yes, do you ever cough anything up from chest?		
3. Do you ever have a feeling of smothering, unable to take a deep breath, or tightness in your chest?		
a. If yes, do you notice that this on any particular day of the week?		
b. If yes, what day or the week?		
c. If yes, do you notice that this occurs at any particular place?		
d. If yes, do you notice that this is worse after you have returned to work after being off for several days?		
4. Have you ever noticed any wheezing in your chest?		
a. If yes, is this only with colds or other infections?		
b. Is this caused by exposure to any kind of dust or other material? If yes, what kind?_____		
5. Have you noticed any burning, tearing, or redness of your eyes when you are at work? If so, explain circumstances:_____		
6. Have you noticed any sore or burning throat or itchy or burning nose when you are at work? If so, explain circumstances:_____		
7. Have you noticed any stuffiness or dryness of your nose?		
8. Do you ever have swelling of the eyelids or face?		
9. Have you ever been jaundiced?		
a. If yes, was this accompanied by any pain?		

10. Have you ever had a tendency to bruise easily or bleed excessively?		
11. Do you have frequent headaches that are not relieved by aspirin or Tylenol?		
a. If yes, do they occur at any particular time of the day or week? If yes, when do they occur? _____		
12. Do you have frequent episodes of nervousness or irritability?		
13. Do you tend to have trouble concentrating or remembering?		
14. Do you ever feel dizzy, light-headed, excessively drowsy or like you have been drugged?		
15. Does your vision ever become blurred?		
16. Do you have numbness or tingling of the hands or feet or other parts of your body?		
17. Have you ever had chronic weakness or fatigue?		
18. Have you ever had any swelling of your feet or ankles to the point where you could not wear your shoes?		
19. Are you bothered by heartburn or indigestion?		
20. Do you ever have itching, dryness, or peeling and scaling of the hands?		
21. Do you ever have a burning sensation in the hands, or reddening of the skin?		
22. Do you ever have cracking or bleeding of the skin on your hands?		
23. Are you under a physician's care? If yes, for what are you being treated? _____		
24. Do you have any physical complaints today? If yes, explain? _____		
25. Do you have other health conditions not covered by these questions? If yes, explain? _____		

You may talk to the health care professional who will review this questionnaire. Please contact EHS for your respective campus for contact information.

Employees Signature: _____
Date:_____