

Medical Surveillance

Asbestos

Workers must undergo both initial and annual medical surveillance, depending on the level and duration of their airborne exposures to asbestos. The medical surveillance requirements are outlined in Title 8 CCR Section 1529.

The initial surveillance is required when:

- An employee is conducting Class I, II, or III work for 30 or more days per year.
- An employee is exposed above the permissible exposure limit (PEL) for 30 or more days per year.
- An employee is required to wear a negative pressure respirator.

The frequency of examinations shall be as follows:

- Prior to assignment of the employee to an area where negative pressure respirators are worn.
- Within 10 days of the 30th day of exposure above the PEL or Class I, II, III work.
- Annually thereafter.
- Within 30 days (before or after) of an employee's termination of employment.

The employer shall ensure that all medical examinations and procedures are performed by or under the supervision of a licensed physician. Persons other than such licensed physicians who administer the pulmonary function testing required by this section shall complete a training course in spirometry sponsored by an appropriate academic or professional institution.

Upon initial examination, the employee shall complete the Initial Medical Questionnaire found in Appendix D of Title 8, Section 1529 (attached). The Periodic Medical Questionnaire (also attached) shall be used each year thereafter.

Medical Questionnaires Mandatory

The following medical questionnaires 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 is the Initial Medical Questionnaire, which must be obtained for all new hires who will be covered by the medical surveillance requirements. Part 2 is the 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 No. _____
- 3) Clock Number _____
- 4) Present Occupation _____
- 5) District _____ Site _____
- 6) Address _____

- 7) Telephone No. _____
- 8) Interviewer _____
- 9) Date _____
- 10) Date of Birth _____
- 11) Place of Birth _____
- 12) Sex: Male Female
- 13) What is your marital status? Single Married Widowed
Separated/Divorced
- 14) Race White Black Asian Hispanic
Indian Other _____
- 15) What is the highest grade completed in school? _____
(For example, 12 years is completion of high school.)

OCCUPATIONAL HISTORY

- 16A. Have you ever worked full time (30 hours per week or more) for six months or more?
Yes No

If "Yes" to 16A:

- 16B. Have you ever worked for a year or more in any dusty job? Yes No
Does Not Apply

Specify job/industry _____ Total Years Worked _____

Was dust exposure: Mild Moderate Severe

- 16C. Have you ever been exposed to gas or chemical fumes in your work? Yes No

Specify job/industry _____ Total Years Worked _____

Was exposure: Mild Moderate Severe

- 16D. 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 the lines the years in which you have worked in any of the following industries, e.g., 1960-1969)

Have you ever worked:

16E. In a mine? _____ Yes No

16F. In a quarry? _____ Yes No

16G. In a foundry? _____ Yes No

16H. In a pottery? _____ Yes No

16I. In a cotton, flax or hemp mill? _____ Yes No

16J. With asbestos? _____ Yes No

PAST MEDICAL HISTORY

17A. Do you consider yourself to be in good health? Yes No

If "No" state reason _____

- 17B. Have you any defect of vision? Yes No
 If "Yes" state nature of defect _____
- 17C. Have you any hearing defect? Yes No
 If "Yes" state nature of defect _____
- 17D. Are you suffering from or have you ever suffered from:
- a. Epilepsy (of fits, seizures, convulsions)? Yes No
 - b. Rheumatic fever? Yes No
 - c. Kidney disease? Yes No
 - d. Bladder disease? Yes No
 - e. Diabetes? Yes No
 - f. Jaundice? Yes No

Chest Colds and Chest Illnesses

- 18A. If you get a cold, does it usually go to your chest? Yes No
 (Usually means more than 1/2 the time.) Don't get colds
- 19A. During the past three years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? Yes No
- 19B. Did you produce phlegm with any of these chest illnesses? Yes No
- 19C. In the last three years, how many such illnesses with (increased) phlegm did you have that lasted a week or more? Number of illnesses _____ No such illnesses
20. Did you have any lung trouble before the age of 16? Yes No
21. Have you ever had any of the following:
- 1A. Attacks of bronchitis Yes No
 If "Yes" to 1A:
 - 1B. Was it confirmed by a doctor? Yes No
 Does not apply
 - 1C. At what age was your first attack? Age in years _____
 Does not apply

- 2A. Pneumonia (include bronchopneumonia)? Yes No
- If "Yes" to 2A:
- 2B. Was it confirmed by a doctor? Yes No
Does not apply
- 2C. At what age did you first have it? Age in years _____
Does not apply
- 3A. Hay fever? Yes No
- If "Yes" to 3A:
- 3B. Was it confirmed by a doctor? Yes No
Does not apply
- 3C. At what age did it start? Age in years _____
Does not apply
- 22A. Have you ever had chronic bronchitis? Yes No
- If "Yes to 23A:
- 22B. Do you still have it? Yes No
Does not apply
- 22C. Was it confirmed by a doctor? Yes No
Does not apply
- 22D. At what age did it start? Age in years _____
Does not apply
- 23A. Have you ever had emphysema? Yes No
- If "Yes" to 23A:
- 23B. Do you still have it? Yes No
Does not apply
- 23C. Was it confirmed by a doctor? Yes No
Does not apply
- 23D. At what age did it start? Yes No
Does not apply

24A. Have you ever had asthma? Yes No

If "Yes" to 24A:

24B. Do you still have it? Yes No
Does not apply

24C. Was it confirmed by a doctor? Yes No
Does not apply

24D. At what age did it start? Yes No
Does not apply

24E. If you no longer have it, at what age did it stop? Age stopped _____
Does not apply

Have you ever had:

25A. Any other chest illness? Yes No
If no, please specify _____

25B. Any chest operations? Yes No
If yes, please specify _____

25C. Any chest injuries? Yes No
If yes, please specify _____

26A. Has a doctor ever told you that you had heart trouble? Yes No

If "Yes" to 26A:

26B. Have you ever had treatment for heart trouble in the past ten years? Yes No

27A. Has a doctor ever told you that you had high blood pressure? Yes No

If "Yes" to 27A:

27B. Have you ever had treatment for high blood pressure? Yes No
(hypertension) in the past ten year? Does not apply

28. When did you last have your chest X-rayed? Year _____

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

What was the outcome? _____

FAMILY HISTORY

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

	FATHER			MOTHER		
	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>
A. Chronic Bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Lung cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Other chest conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Is parent currently alive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Please specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Please specify cause of death _____						

Cough

31A. 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 31C.] Yes No

31B. Do you usually cough as much as 4 to 6 times a day for four or more days out of the week? Yes No

31C. Do you usually cough at all on getting up or first thing in the morning? Yes No

31D. Do you usually cough at all during the rest of the day or at night? Yes No

If yes to any of the above (31A, B, C, or D), answer the following. If no to all, check does not apply and skip to next page.

31E. Do you usually cough like this on most days for three consecutive months or more during the year? Yes No
Does not apply

31F. For how many years have you had the cough? Number of year: _____
Does not apply

32A. Do you usually bring up phlegm from you 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.] Yes No

32B. Do you usually bring up phlegm like this as much as twice a day for four or more days out of the week? Yes No

32C. Do you usually bring up phlegm at all on getting up or the first thing in the morning? Yes No

32D. Do you usually bring up phlegm at all during the rest of the day or at night? Yes No

If yes to any of the above (32A, B, C, or D), answer the following. If no to all of the following, check does not apply and skip to 33A.

32E. Do you bring up phlegm like this on most days for three consecutive months or more during the year? Yes No

32F. For how many years have you had trouble with phlegm? Number of years: _____
Does not apply

Episodes of Cough and Phlegm

33A. Have you had periods or episodes of (increased*) cough and phlegm lasting for three weeks or more each year? (*For persons who usually have cough and/or phlegm.) Yes No

If "Yes" to 33A:

33B. For how long have you had at least one such episode per year? Number of years: _____
Does not apply

Wheezing

34A. Does your chest ever sound wheezy or whistling

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| 1. When you have a cold? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Occasionally apart from colds? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Most days or nights? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If "Yes" to 1, 2, or 3 in 34A:

34B. For how many years has this been present? Number of years: _____
Does not apply

35A. Have you ever had an attack of wheezing that has made you feel short of breath? Yes No

35B. How old were you when you had your first such attack? Age in years: _____
Does not apply

35C. Have you had two or more such episodes? Yes No

35D. Have you ever required medicine or treatment for the(se) attack(s)? Yes No

Breathlessness

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

Nature of condition(s): _____

- 37A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill? Yes No

If "Yes" to 37A:

- 37B. Do you have to walk slower than people of your age on the level because of breathlessness? Yes No

- 37C. Do you ever have to stop for breath when walking at your own pace on the level? Yes No

- 37D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level? Yes No

- 37E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs? Yes No

Tobacco Smoking

- 38A. Have you ever smoked cigarettes? ("No" means less than 20 packs of cigarettes or 12 oz of tobacco in a lifetime or less than one cigarette a day for one year.) Yes No

If "Yes" to 38A:

- 38B. Do you now smoke cigarettes (as of one month ago)? Yes No

- 38C. How old were you when you first started regular cigarette smoking? Age in years: _____
Does not apply

- 38D. If you have stopped smoking cigarettes completely, how old were you when you stopped?
Age stopped: _____
Check is still smoking
Does not apply

- 38E. How many cigarettes do you smoke per day now? Cigarettes per day _____
Does not apply

- 38F. On the average of the entire time you smoked, how many cigarettes did you smoke per day? Cigarettes per day _____
Does not apply

- 38G. Do or did you inhale the cigarette smoke? Does not apply
Not at all
Slightly
Moderately
Deeply
- 39A. Have you ever smoked a pipe regularly? Yes No
 (“Yes” means more than 12 oz of tobacco in a lifetime.)

If “Yes” to 39A:

- 39B1. How old were you when you started to smoke a pipe regularly? Age _____
- 39B2. If you have stopped smoling a pipe completely, how old were you when you stopped?
 Age stopped _____
 Check if still smoking
 Pipe
 Does not apply

- 39C. On the average, over the entire time you smoked a pipe how much pipe tobacco did you
 smoke per week? _____ oz per week (a
 standard pouch of tobacco
 contains 1½ oz)
 Does not apply

- 39D. How much pipe tobacco are you smoking now? _____ oz per week
 Not currently smoking a
 pipe

- 39E. Do you or did you inhale the pipe smoke? Never smoked
Not at all
Slightly
Moderately
Deeply

- 40A. Have you ever smoked cigars regularly? Yes No
 (“Yes” means more than one cigar a week for a year.)

If “Yes” to 40A:

FOR PERSONS WHO HAVE EVER SMOKED CIGARS

- 40B1 How old were you when you started smoking cigars regularly? Yes No
- 40B2 If you have stopped smoking cigars completely, how old were you when you stopped?
Yes No

- 40C. On the average, over the entire time you smoked cigars, how many cigars did you smoke per week? Cigars per week _____
Does not apply
- 40D. How many cigars are you smoking per week now? Cigars per week _____
Not currently smoking cigars
- 40E. Do (or did) you inhale the cigar smoke?
Never smoke
Not at all
Slightly
Moderately
Deeply

Signature _____ Date _____

RECENT MEDICAL HISTORY

12A. Do you consider yourself to be in good health? Yes No

If "No", state reason _____

12B. In the past year, have you developed:	Epilepsy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Rheumatic fever?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Kidney disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Bladder disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Diabetes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Jaundice?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Cancer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Chest Colds and Chest Illnesses

13A. If you get a cold, does it usually go to your chest? Yes No
(Usually means more than 1/2 the time.) Don't get colds

14A. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed? Yes No
Does not apply

If "Yes" to 14A:

14B. Did you produce phlegm with any of these chest illnesses? Yes No
Does not apply

14C. In the past year, how many such illnesses with (increased) phlegm did you have that lasted a week or more? Number of illnesses _____
No such Illnesses

Respiratory System

15. In the past year, have you had:	<u>Yes or No</u>	<u>Further Comment on Positive Answers</u>
Asthma	_____	_____
Bronchitis	_____	_____
Hay Fever	_____	_____
Other allergies	_____	_____
Pneumonia	_____	_____
Tuberculosis	_____	_____
Chest surgery	_____	_____
Other lung problems	_____	_____
Heart disease	_____	_____

Do you have:	<u>Yes or No</u>	<u>Further Comment on Positive Answers</u>
Frequent colds?	_____	_____
Chronic cough?	_____	_____
Shortness of breath when walking or climbing one flight of stairs?	_____	_____
Do you:		
Wheeze?	_____	_____
Cough up phlegm?	_____	_____
Smoke cigarettes?	_____	_____

Signature_____

Date_____