

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 No.	Social Security No.	For Official Use Only Date Entered by:	Be	RAD	CHEM	2
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Name
 Last First Middle

Home Address **Home Phone** ()
 Street Apt Number

City/State/Zip
 City State Zip Code

Sex Male (M) Female (F) **Age** **Date of Birth** / / **Place of Birth**
 City State

Race White (W) Black (B) Hispanic (H) Asian (A) Native American Indian (I) Other (O)

Marital Status Never Married (N) Married (M) Widowed (W) Divorced (D) Separated (S)

Employment Status Current (C) Inactive (I) Retired (R)
 DOE Current (DOEC) DOE Inactive (DOEI) Long Term Disability (LTD)
 WSI Current (WSIC) WSI Inactive (WSII)
 JA Jones Current (JAJC) JA Jones Inactive (JAJI)
 Sub Contractor, Current (SUBC) Sub Contractor, Inactive (SUBI)
 Employed elsewhere? What type of work?
 Of all the paid jobs you ever had, what KIND of work did you do the longest?

Last Year of Education Completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
 Primary Grades College Masters Doctorate

Closest Living Relative
 Name Relationship Phone
 Street Apartment
 City State Zip Code

Personal Physician
 Name Phone

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

Statement of Your Personal Health in Your Own Words

Do you have any work-related health changes? Yes No If yes, please explain:
 Have you 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? 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 back of page if more room required)

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

How often do you eat fruits and vegetables? Daily (D) 3-5 Times Week(3) 1-2 Times Week (1) 1-2 times Month(M) Never (N)

Signature: _____ Date: _____ **Termination Date** _____ **Appointment 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.

	WORK BEFORE	WORK AT	WORK AFTER	OTHER
Chemicals				
101 Acrylimide	_____	_____	_____	_____
102 Acetone	_____	_____	_____	_____
103 Alcohol	_____	_____	_____	_____
104 Ammonia	_____	_____	_____	_____
105 Benzo(a)pyrine	_____	_____	_____	_____
106 Benzene	_____	_____	_____	_____
107 Benzidene	_____	_____	_____	_____
108 1,3 Butadiene	_____	_____	_____	_____
109 Carbon Disulfide	_____	_____	_____	_____
110 Carbon Monoxide	_____	_____	_____	_____
112 Chloroform	_____	_____	_____	_____
113 Ethylene Oxide	_____	_____	_____	_____
114 Chlorine	_____	_____	_____	_____
115 Chloroform	_____	_____	_____	_____
116 Chromic Acid Mist	_____	_____	_____	_____
117 Cutting Oils	_____	_____	_____	_____
118 Cyanide	_____	_____	_____	_____
119 Cyclohexane	_____	_____	_____	_____
120 Ethyl Alcohol	_____	_____	_____	_____
121 Freon	_____	_____	_____	_____
122 Graphite	_____	_____	_____	_____
123 Hydrogen Fluoride	_____	_____	_____	_____
124 Hydrazine	_____	_____	_____	_____
125 Hydrochloric Acid	_____	_____	_____	_____
126 Hydrogen Peroxide	_____	_____	_____	_____
127 Isocyanates	_____	_____	_____	_____
128 Isopropyl Alcohol	_____	_____	_____	_____
129 Fluorides	_____	_____	_____	_____
130 Formaldehyde	_____	_____	_____	_____
131 Nitric Acid	_____	_____	_____	_____
132 Methyl Alcohol	_____	_____	_____	_____
133 Methylene Chloride	_____	_____	_____	_____
134 Methylene Dianiline	_____	_____	_____	_____
135 Potassium Chromate	_____	_____	_____	_____
136 Polychlorinated Biphenyls (PCB's)	_____	_____	_____	_____
137 Pesticides	_____	_____	_____	_____
138 Phenols	_____	_____	_____	_____
139 Phosgene	_____	_____	_____	_____
140 Plastics	_____	_____	_____	_____
141 Propylene Oxide	_____	_____	_____	_____
142 Percloroethylene	_____	_____	_____	_____
143 Tetrabromoethylene	_____	_____	_____	_____
144 Trichloroethylene	_____	_____	_____	_____
145 Trichloroethane	_____	_____	_____	_____
146 Toluene	_____	_____	_____	_____
147 Uranyl Nitrate	_____	_____	_____	_____
148 Vinyl Chloride	_____	_____	_____	_____
149 Xylene	_____	_____	_____	_____

EXPOSURE HISTORY

	WORK BEFORE	WORK AT	WORK AFTER	OTHER
Paints/Adhesives				
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 Nickle	_____	_____	_____	_____
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 Fibreglass	_____	_____	_____	_____
605 Sandblasting	_____	_____	_____	_____
Other Hazards				
701 Loud Noise	_____	_____	_____	_____
702 Loud Impact Noise	_____	_____	_____	_____
703 Heat	_____	_____	_____	_____
704 Cold	_____	_____	_____	_____
705 Heights	_____	_____	_____	_____
706 Vibration	_____	_____	_____	_____
801 Other (List Below)	_____	_____	_____	_____
Comments				

Page 4 EXPOSURE HISTORY

HEALTH HISTORY

Please CIRCLE the appropriate responses and provide the year diagnosed.

Do you or have you had?	Yes	No	Un- sure	Year Diag	Do you or have you had?	Yes	No	Un- sure	Year Diag
1 Asthma	Y	N	U	___	47 Frequent/severe headaches	Y	N	U	___
2 Allergies	Y	N	U	___	48 Depression or anxiety	Y	N	U	___
3 Bronchitis	Y	N	U	___	49 Nervousness	Y	N	U	___
4 Emphysema	Y	N	U	___	50 Frequent fatigue/tiredness	Y	N	U	___
5 Shortness of breath	Y	N	U	___	51 Nausea	Y	N	U	___
6 Heart disease or attack	Y	N	U	___	52 Numbness (hands, limbs, feet)	Y	N	U	___
7 High blood pressure	Y	N	U	___	53 Paralysis (hands, limbs, feet)	Y	N	U	___
8 Anemia or blood disorders	Y	N	U	___	54 Weakness (hands, limbs, feet)	Y	N	U	___
9 Cough	Y	N	U	___	55 Alcohol/drug problems	Y	N	U	___
10 Cough up blood	Y	N	U	___	60 Speech impairment	Y	N	U	___
11 Hay fever	Y	N	U	___	61 Vision impairment	Y	N	U	___
12 Lung problems	Y	N	U	___	62 Hearing impairment	Y	N	U	___
13 Pneumonia	Y	N	U	___	70 Arthritis	Y	N	U	___
14 Tuberculosis	Y	N	U	___	71 Rheumatism	Y	N	U	___
15 COPD (Chronic obstructive pulmonary disease)	Y	N	U	___	72 Joint disorders	Y	N	U	___
20 Kidney disease	Y	N	U	___	73 Chronic back pain	Y	N	U	___
21 Prostate problems (not cancer)	Y	N	U	___	74 Chronic neck pain	Y	N	U	___
22 Urinary tract disorders	Y	N	U	___	76 Skin disease	Y	N	U	___
30 Cirrhosis of liver	Y	N	U	___	77 Skin rash/allergies	Y	N	U	___
31 Liver disease	Y	N	U	___	78 Skin sensitivities	Y	N	U	___
32 Hepatitis	Y	N	U	___	80 Sterility or infertility	Y	N	U	___
33 Stomach problems	Y	N	U	___	81 Miscarriage(s)	Y	N	U	___
34 Ulcers	Y	N	U	___	82 Spontaneous abortion(s)	Y	N	U	___
35 Gall bladder problems	Y	N	U	___	83 Child with birth defects	Y	N	U	___
36 Intestinal problems	Y	N	U	___	84 Birth defects (self)	Y	N	U	___
37 Diabetes	Y	N	U	___	85 Disabilities	Y	N	U	___
40 Epilepsy	Y	N	U	___	90 Cancer	Y	N	U	___
41 Muscular dystrophy	Y	N	U	___	91 Leukemia	Y	N	U	___
42 Parkinson's disease	Y	N	U	___	92 Skin cancer	Y	N	U	___
43 Seizures	Y	N	U	___	93 Prostate cancer	Y	N	U	___
44 Stroke	Y	N	U	___					
45 Senile dementia/Alzheimers	Y	N	U	___					
46 Tremors	Y	N	U	___					

Other conditions (specify)

.....

If other cancer, please specify type and location:

.....

Do you have any disabilities, either congenital (born with) or other? Yes No If yes, please explain.

Do you have, or have you had any chronic or serious illnesses or surgeries? Yes No If yes, please explain.

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**HEALTH and EXPOSURE HISTORY
Beryllium Health Surveillance Program**

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

Date Completed / /	Employee No.	Social Security No.	For Official Use Only Date Entered _____ By: _____
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Name
Last First Middle

CURRENT EMPLOYEES PLEASE FILL IN EXTENSION, DEPARTMENT, AND BUILDING

Extension	Department	Building
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EVERYONE, PLEASE FILL IN THE FOLLOWING INFORMATION

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

While at _____, did you feel you were ever exposed to beryllium? Yes No

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

In what way(s) do you feel you may have been exposed to beryllium? _____

Other than at _____, did you ever work with beryllium? Yes No

If yes, where/name of company _____

Did you ever work:

In a mine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year started _____	Year ended _____
In a quarry?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year started _____	Year ended _____
In a foundry?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year started _____	Year ended _____
In a pottery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year started _____	Year ended _____
With asbestos?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year started _____	Year ended _____
In a cotton, flax or hemp mill?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 Y wheezing that made you feel short of breath?	N	_____	
◆ Are you troubled by shortness of breath when <u>hurrying</u> on level ground or Y walking up a slight hill?	N	_____	
◆ Do you ever have to stop to catch your breath when walking at your own Y pace on level ground?	N	_____	
◆ Do you have to walk slower than people of your age on level ground because Y of breathlessness?	N	_____	
◆ Are you presently taking any prescription medication for pulmonary (lung) Y problems?	N	_____	

If yes, please list: _____

Signature: _____ Date: _____

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

Comments	For Office Use Only
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EXPOSURE HISTORY

FAMILY HISTORY

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

	Father or Father's Family	Mother or Mother's Family	Brother or Sister		Not Known
1 Cancer	F	M	B	S	U
2 Neurological disease (stroke, epilepsy, Alzheimer, etc)	F	M	B	S	U
3 Psychological problems (nervous breakdown, depression, etc.) .	F	M	B	S	U
4 Respiratory disease	F	M	B	S	U
5 Heart disease	F	M	B	S	U
6 Kidney disease	F	M	B	S	U
7 Metabolic disease (diabetes, thyroid, etc.)	F	M	B	S	U
8 Gastrointestinal disease (ulcers, etc.)	F	M	B	S	U
9 Musculo-skeletal disease (arthritis, etc.)	F	M	B	S	U
10 Impairments (speech, vision, hearing)	F	M	B	S	U
11 Reproductive problems	F	M	B	S	U
12 Birth defects	F	M	B	S	U
13 Immunological problems	F	M	B	S	U
14 Alcohol consumption	F	M	B	S	U
15 Tobacco use (smoking, chewing)	F	M	B	S	U
16 Other	F	M	B	S	U

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

Additional Information

ADDITIONAL INFORMATION

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

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 last month) Yes No

How many cigarettes do you now 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 means more than 1 cigar a week for 1 year) Yes No

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? 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: _____ (Avg/bottles/wk): 1 or less 2 3 4 5 6 7 8 9 10 or more

Wine - Number of years: _____ (Avg/glasses/wk): 1 or less 2 3 4 5 6 7 8 9 10 or more

Liquor - Number of years: _____ (Avg/ounces/wk): 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 had children with birth defects please give dates of birth. _____

Comments: