



Industrial Medical Associates, P.C.

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**STORE RECORD
ACCORDING TO FEDERAL
REGISTER 1910.20(d)**

HAZARDOUS WASTES MEDICAL QUESTIONNAIRE

NAME: _____ HOME PHONE: _____
 STREET ADDRESS: _____ WORK PHONE: _____
 CITY: _____ BIRTH DATE: _____
 SOCIAL SECURITY#: _____

IN DECEMBER 1986, OSHA ISSUED AN INTERIM STANDARD EMPHASIZING THE MEDICAL SURVEILLANCE OF WORKERS EXPOSED TO HAZARDOUS WASTES. THIS QUESTIONNAIRE FOLLOWS THOSE GUIDELINES.

If you suspect or know of recent or remote exposures to the following, please check the appropriate box. If you are not sure, please leave blank:

Have you been exposed to any of the following?

	Yes	No
Dioxins.....	<input type="checkbox"/>	<input type="checkbox"/>
Hydrocarbons.....	<input type="checkbox"/>	<input type="checkbox"/>
Heavy metals.....	<input type="checkbox"/>	<input type="checkbox"/>
Herbicides.....	<input type="checkbox"/>	<input type="checkbox"/>
Insecticides.....	<input type="checkbox"/>	<input type="checkbox"/>
PCB's.....	<input type="checkbox"/>	<input type="checkbox"/>
Carcinogens.....	<input type="checkbox"/>	<input type="checkbox"/>
Noise.....	<input type="checkbox"/>	<input type="checkbox"/>
Asbestos.....	<input type="checkbox"/>	<input type="checkbox"/>
Radioactivity.....	<input type="checkbox"/>	<input type="checkbox"/>
Fumes.....	<input type="checkbox"/>	<input type="checkbox"/>
Dust.....	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

Do you have or have you ever had?

	Yes	No
Heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Cough.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>
Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>
Seizure disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
Numbness of hands or feet.....	<input type="checkbox"/>	<input type="checkbox"/>
Drowsiness.....	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia.....	<input type="checkbox"/>	<input type="checkbox"/>
Nausea.....	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting.....	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal cramps.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Skin disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Rash.....	<input type="checkbox"/>	<input type="checkbox"/>
Spine or joint disease.....	<input type="checkbox"/>	<input type="checkbox"/>

Comments _____

