Industrial Medical Associates, P.C.

☐ 961 Canal St., Syracuse, NY 13210 (315) 478-1977 Fax (315) 475-2909
☐ 151 Lawrence Road E, North Syracuse, NY 13212 (315) 458-1335 Fax (315) 458-1738
☐ 222 Teall Ave, Suite 100, Syracuse, NY 13210 (315) 478-1977 Fax (315) 428-9223

**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	☐	☐
Hydrocarbons	☐	☐
Heavy metals	☐	☐
Herbicides	☐	☐
Insecticides	☐	☐
PCB’s	☐	☐
Carcinogens	☐	☐
Noise	☐	☐
Asbestos	☐	☐
Radioactivity	☐	☐
Fumes	☐	☐
Dust	☐	☐

Other ____

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Alcohol

What is your approximate daily intake of alcohol?

☐ None ☐ Occasional ☐ Less than 2 ☐ 3 to 5 ☐ Over 5

Tobacco

Have you ever smoked cigarettes? Yes ☐ No ☐

Do you smoke now? Yes ☐ No ☐

How many cigarettes per day? Less than 15 ☐ 15-24 ☐ 25-34 ☐ 35+ ☐

Most you every smoked per day? Less than 15 ☐ 15-24 ☐ 25-34 ☐ 35+ ☐

Total years you have smoked? 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35+ ☐

If you quit, how many years ago? ______________________________

At what age did you start smoking? ______________________________

At what age did you stop smoking? ______________________________

Do you smoke pipes or cigars? ______________________________

How many per day? ______________________________

Do you inhale pipe or cigar smoke? ______________________________

Visual

Do you wear glasses? Yes ☐ No ☐

Do you wear contact lenses? Yes ☐ No ☐

Auditory

Do you suspect you have impaired hearing? Yes ☐ No ☐

Allergies

Do you have any allergies? Yes ☐ No ☐

Temperature Intolerance

Do you consider yourself unusually sensitive to hot or cold temperatures? Yes ☐ No ☐

Do you have or have you ever had?

	Yes	No
Heart disease	☐	☐
High blood pressure	☐	☐
Chest pain	☐	☐
Heart murmur	☐	☐
Lung disease	☐	☐
Cough	☐	☐
Asthma	☐	☐
Sinusitis	☐	☐
Shortness of breath	☐	☐
Headaches	☐	☐
Fatigue	☐	☐
Dizziness	☐	☐
Seizure disorder	☐	☐
Numbness of hands or feet	☐	☐
Drowsiness	☐	☐
Insomnia	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Jaundice	☐	☐
Abdominal cramps	☐	☐
Kidney disease	☐	☐
Skin disease	☐	☐
Rash	☐	☐
Spine or joint disease	☐	☐

Comments ____

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