

OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM
OCCUPATIONAL/MEDICAL QUESTIONNAIRE
(See Form ARS-182A/B for Privacy Act Notification)

DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME
SOCIAL SECURITY NUMBER	DATE OF BIRTH <i>(mm/dd/yyyy)</i>	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RACE <input type="checkbox"/> BLACK/NOT HISPANIC ORIGIN <input type="checkbox"/> AMERICAN INDIAN/ ALASKAN NATIVE <input type="checkbox"/> WHITE/NOT HISPANIC ORIGIN <input type="checkbox"/> OTHER <i>(specify):</i> <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN/PACIFIC ISLANDER		MARITAL STATUS <input type="checkbox"/> SINGLE/NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED/LIVING TOGETHER <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED

EMPLOYEE'S MAILING ADDRESS *(Where confidential mail can be delivered)*

STREET	APARTMENT NO.	
CITY	STATE	ZIP CODE

EMPLOYEE'S PHYSICIAN

LAST NAME	OFFICE TELEPHONE <i>(Include Area Code)</i>	
STREET ADDRESS	SUITE NO.	
CITY	STATE	ZIP CODE

EMPLOYEE'S CURRENT JOB

LOCATION <i>(City)</i>	STATE	ZIP CODE
REGULAR WORKPLACE <i>(Building and Room No.)</i>	GS SERIES	
JOB TITLE	YEARS IN PRESENT JOB	

Have you ever been a resident outside the United States? No Yes

If yes, please list the location(s) and date(s).	FROM MONTH/YEAR	TO MONTH/YEAR
1.		
2.		
3.		
4.		
5.		
6.		

OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM

RECREATIONAL HISTORY

(Please print)

Do you now or have you in the past, done any of the following as a hobby or during your spare time?				Do you now or have you in the past, come into contact with any of the following during your spare time?			
	NO	PRE-VIOUSLY	CUR-RENTLY		NO	PRE-VIOUSLY	CUR-RENTLY
Auto mechanic work				Acids			
Auto body work				Bonding agents or industrial glues			
Been exposed to rubber cement for extended periods of time				Cleaning fluids			
Carpentry				Fertilizers			
Ceramics				Gasoline or other petroleum products			
Etching/metal work/jewelry/metal sculpture				Herbicides or weed killers			
Furniture refinishing				Insecticides/pesticides			
House painting				Insulation material			
Lawn/Garden maintenance or farming				Lacquer, varnish or enamel paints			
Make your own cartridges/salvage spent cartridges				Leather dyes			
Make your own fishing sinkers				Paint thinners and removers			
Oil painting				Soldering agents			
Pottery				Solvents/degreasers			
Recreational hunting/shooting				Wood stains			

In your work are you now or have you been exposed to any of the following agents?

	PRE-SENT			PRE-SENT			PRE-SENT	
	PAST			PAST			PAST	
Inorganic flourides			Excessive noise			Asbestos		
Lead			Nitrogen oxides			Suspect or known carcinogens		
Benzene			Crystalline silica			Pesticides		
Coke oven emissions			Nitric acid			Bacteria or viruses		
Inorganic arsenic			Ammonia			Primate animals		
Methylene chloride			Beryllium			Vibrating tools		
Vinyl chloride			Phosgene			Radiation (Ionizing)		
Toluene diisocyanate			Allyl chloride			Radiation (Non-Ionizing)		

Please make a list of those substances that you handle in your work. **Star (*)** those that particularly concern you from a health standpoint.

Indicate any symptoms that you have experienced that might be due to exposure at work and indicate the suspected cause.

SYMPTOM:

CAUSE:

Have you experienced any **job related** illnesses or injuries since being employed by the USDA? No Yes

IF YES, GIVE DETAILS:

MONTH AND YEAR:

OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM

SMOKING HISTORY

CIGARETTES: Have you ever smoked cigarettes regularly?
 No Yes (If yes, please answer the following questions.)
 ("No" means never smoked, or smoked less than 20 packs of cigarettes or 12 ozs. of tobacco in life-time, or less than 1 cigarette a day for one year.)

a. How old were you when you started smoking cigarettes regularly? _____ Years

b. Do you still smoke cigarettes? No Yes
 If yes, how many cigarettes do you now smoke per day? _____ Cig./da

c. If you have stopped smoking cigarettes, how old were you when you stopped? _____ Years

d. On the average, of the entire time you have smoked, how many cigarettes did you smoke per day? _____ Cig./da

e. Do, or did you inhale the cigarette smoke? No Yes

PIPES: Have you ever smoked a pipe regularly?
 No Yes (If yes, please answer the following questions.)
 ("No" means never smoked, or smoked no more than 12 ozs. of pipe tobacco in your life-time.)

a. How old were you when you started smoking pipes regularly? _____ Years

b. Do you still smoke pipes? No Yes
 If yes, how many ounces of pipe tobacco do you now smoke per week? _____ Ozs./week

c. If you have stopped smoking a pipe, how old were you when you stopped? _____ Years

d. On the average, of the entire time you have smoked, how many ounces of tobacco did you smoke per day? _____ Ozs./week

e. Do, or did you inhale the pipe smoke? No Yes

CIGARS: Have you ever smoked cigars regularly?
 No Yes (If yes, please answer the following questions.)
 ("No" means never smoked, or smoked no more than 1 cigar a week for 1 entire year.)

a. How old were you when you started smoking cigars regularly? _____ Years

b. Do you still smoke cigars? No Yes
 If yes, how many cigars do you now smoke per day? _____ Cigars/day

c. If you have stopped smoking cigars, how old were you when you stopped? _____ Years

d. On the average, of the entire time you have smoked cigars, how many cigars did you smoke per day? _____ Cigars/day

e. Do, or did you inhale the cigar smoke? No Yes

TOBACCO CHEWING: Have you ever chewed tobacco regularly?
 No Yes (If yes, please answer the following questions.)

a. How old were you when you started chewing tobacco regularly? _____ Years

b. Do you still chew tobacco? No Yes

c. If you have stopped chewing tobacco, how old were you when you stopped? _____ Years

SNUFF: Have you ever used snuff regularly?
 No Yes (If yes, please answer the following questions.)

a. How old were you when you started using snuff regularly? _____ Years

b. Do you still use snuff? No Yes

c. If you have stopped using snuff, how old were you when you stopped? _____ Years

LIFE-STYLE HISTORY

ALCOHOLIC BEVERAGES: Do you now or have you ever drunk alcoholic beverages (such as wine, beer, or hard liquor) regularly?
 No Yes (If yes, please answer the following questions.)

a. Which of the following do you regularly drink? (Check all that apply.)
 Wine
 Beer
 Liquor

b. Have you stopped drinking regularly? No Yes
 If yes, how many years ago did you stop? _____ Years

c. How much do (did) you drink on an average day or in an average week?
 Less than 1 drink per day, or less than 7 drinks per week.
 1 to 2 drinks per day, or 7 to 17 drinks per week.
 3 to 4 drinks per day, or 18 to 31 drinks per week.
 5 or more drinks per day, or more than 31 drinks per week.

EXERCISE: Do you get exercise on a regular basis?
 No Yes (If yes, please answer the following questions.)

a. How many days per week? _____ Days/week

b. How many minutes do you exercise? _____ Minutes

c. Describe the kind of exercise you get:

DIET:

a. Do you drink more than two cups of coffee or tea a day? No Yes

b. Do you restrict your diet? (If yes, which of the following items do you restrict?) No Yes
 Meat Sodium or Salt
 Sugar Foods high in cholesterol
 Other (describe): _____

c. How many years have you been restricting your diet? _____ Years

d. Why are you restricting your diet?
 Religious reasons Medical reasons
 Other (describe): _____

**OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM
MEDICAL HISTORY**

CARDIOVASCULAR: Have you ever had or do you now have any of the following illnesses or problems with your heart or blood vessels?

	NO	YES PAST	YES CURRENT
Heart Attack			
Angina Pectoris			
Heart Murmur			
Enlarged Heart			
Stroke			
High Blood Pressure			
Other problems with blood pressure			
Episodes of chest pains, tightness, discomfort			
Rheumatic Heart Disease			
Arteriosclerosis			
Varicose Veins			
Other (specify):			
Have you ever had heart surgery? (If yes,			

DIGESTIVE SYSTEM: Have you ever had or do you now have any of the following illnesses or problems with your digestive system?

	NO	YES PAST	YES CURRENT
Blood in stool			
Stomach or Duodenal Ulcer			
Appendicitis			
Nervous stomach			
Colitis			
Frequent constipation			
Frequent diarrhea			
Frequent indigestion			
Stomach pain			
Hiatal hernia or rupture			
Diverticulitis			
Hemorrhoids or piles			
Other (specify):			

RESPIRATORY ILLNESS/CONDITIONS: Have you had or do you now have any of the following illnesses or problems with your lungs?

	NO	YES PAST	YES CURRENT
Frequent Colds			
Coughed up Blood			
Chronic Cough			
Lung or Breathing difficulties or Shortness of Breath			
Asthma			
Emphysema			
Pneumonia			
Tuberculosis			
Bronchitis			
Pleurisy			
Other (specify):			
Have you ever had surgery on your lungs? (If yes, describe):			

system? (If yes, describe):

LIVER AND SPLEEN: Have you ever or do you now have any of the following illnesses or problems with your liver, spleen, or gallbladder?

	NO	YES PAST	YES CURRENT
Cirrhosis of the liver			
Hepatitis			
Jaundice			
Gallbladder disease			
Gallbladder stones			
Injury to your spleen			
Other (specify):			

Have you ever had surgery on your liver or spleen? (If yes, describe):

Have you ever had or do you now have any of the following problems with your mouth, nose or throat?

	NO	YES PAST	YES CURRENT
Nasal passages frequently irritated			
Nose Bleeds often			
Throat is often irritated			
Voice is hoarse when you do not have a cold			
Mouth/Gums frequently have sores/ulcers			
Gums shrinking, irritated or bleeding			
Other (specify):			

ENDOCRINE: Have you ever had or do you now have any of the following illnesses or conditions?

	NO	YES PAST	YES CURRENT
Hypoglycemia			
Diabetes			
Goiter			
Thyroid disease or disorder			
Swollen glands or nodes			
Pancreatitis			
Other gland problems (specify):			

KIDNEYS/URINARY TRACT: Have you ever had or do you now have any of the following illnesses or problems with your kidneys or urinary tract?

	NO	YES PAST	YES CURRENT
Blood in urine			
Pain or burning when urinating			
Kidney disease			
Kidney infection			
Kidney stones			
Nephritis (Bright's Disease)			
Bladder Infection			
Prostate gland enlargement/infection (Males only)			
Tumor in urinary tract			
Other (specify):			

Have you ever had surgery on your kidneys or urinary tract? (If yes, describe):

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MEDICAL HISTORY (Continued)

ALLERGIES (Continued)

	NO	YES PAST	YES CURRENT
House dust			
Animal dander, feathers, or fur			
Sunlight or cold			
Other (If yes, please list):			
Do you react with:			
Rash			
Hives			
Hay fever symptoms			
Breathing difficulty			
Other (If yes, describe):			

CANCER: Have you ever been diagnosed with cancer?
 No Yes (If yes, list the year and type of diagnosis.)

Type	Year	Specific Tissue Diagnosis (If available)
Skin		
Colon		
Breast		
Lung		
Prostate		
Cervical		

Other (If yes, specify type and describe tissue diagnosis and year):

EARS: Have you ever had or do you now have any of the following problems with your ears or your hearing?

	NO	YES PAST	YES CURRENT
Difficulty in hearing			
Tinnitus (ringing/buzzing) in right ear			
in left ear			
Nasal allergy			
Vertigo (dizziness)			
Perforation of the ear drum			
Ear drainage (caused by infection or injury)			
High fever			
Infection of inner ear			
Hearing loss by blood relatives (such as grandparents, parents, aunts, uncles, brothers, or sisters) before they reached the age of 60			
Other problems with your ears (If yes, describe):			

INFECTIOUS/CHILDHOOD DISEASES: Have you had or do you now have:

	NO	YES PAST	YES CURRENT
Mononucleosis			
Meningitis			
Malaria			
Polio			
Rheumatic fever			
Scarlet fever			
Mumps			
Measles			
Chicken pox			
German measles			
Tonsillitis			
Gonorrhea			
Syphilis			

FAMILY HISTORY: Have any of your blood relatives (parents, grandparents, brothers, sisters, aunts, uncles or children) had any of the following illnesses or conditions?

	NO	YES PAST	YES CURRENT
Anemia			
Alcoholism			
Allergies			
Arthritis			
Asthma			
Bleeding disorders (free bleeder)			
Breast cancer			
Cervical cancer			
Chronic bronchitis			
Congenital malformations (birth defect)			
Diabetes (sugar)			
Digestive or bowel disease			
Eczema			
Emphysema			
Epilepsy			
Glaucoma			
Gout			
Hay fever			
Heart attack			
Heart disease			
High blood pressure			
Kidney or bladder disease			
Kidney stones			
Liver or gallbladder disease			
Lung cancer			
Mental illness			
Mental retardation			
Nervous system disease			
Psoriasis			

EYES: Have you ever had or do you now have any of the following problems with your eyes or your vision?

	NO	YES PAST	YES CURRENT
Glaucoma			
Cataracts			
Conjunctivitis (pink eye)			
Blurring of eyesight			
Vision getting worse			
Seeing double			
Seeing halos around lights			
Pain in the eyeball			
Eyes are often bloodshot			
Right eye injured (e.g., scratched, burned, cut, etc.)			
Left eye			
Right eye Foreign object accidentally embedded in the eye			
Left eye			
Other problems with your eyes (If yes, describe):			
Do you wear glasses?			
Do you wear contact lenses?			

(NOTE: This section continues at top of next page.)

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MEDICAL HISTORY (Continued)

FAMILY HISTORY (Continued)

	NO	YES PAST	YES CURRENT
Sickle cell disease or trait			
Stroke			
Thyroid disease			
Tuberculosis (T.B.)			
Ulcer (stomach, duodenal, peptic)			
Other cancers or leukemia			
Is your mother still living?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
If not, please give age at death:	_____ Years		
and cause of death:	_____		
Is your father still living?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
If not, please give age at death:	_____ Years		
and cause of death:	_____		
Are you aware of any disease or illnesses that run in your family? (If yes, please list below):	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

IMMUNIZATIONS, VACCINES, ANTITOXINS: If you have received any of the following, check the appropriate box(es) and give the approximate dates, if known.

<input type="checkbox"/> Tetanus	Date _____ (mm/dd/yyyy)
<input type="checkbox"/> Poliomyelitis	_____
<input type="checkbox"/> Influenza	_____
<input type="checkbox"/> Typhoid	_____
<input type="checkbox"/> Diphtheria	_____
<input type="checkbox"/> Rabies	_____
<input type="checkbox"/> Rubella (German measles)	_____
<input type="checkbox"/> Measles (Rubeola or red measles)	_____
<input type="checkbox"/> BCG	_____
<input type="checkbox"/> Yellow Fever	_____
<input type="checkbox"/> Smallpox	_____
<input type="checkbox"/> RhoGAM (Rh immune globulin)	_____
<input type="checkbox"/> Immune serum globulin for hepatitis	_____
<input type="checkbox"/> Others (please list):	_____
<input type="checkbox"/> Mantoux, patch test, or other skin test for tuberculosis	_____
Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	_____

MEDICATIONS: Have you taken any of the following medications in the last

	NO	YES PAST	YES CURRENT
Antacids			
Antibiotics (e.g., penicillin, ampicillin, tetracycline)			
Antihistamines			
Aspirin			
Benzedrine / Dexedrine			
Birth control pills			
Blood thinners (anti-coagulants)			
Codeine			
Cortisone or other steroids			
Diet pills			
Digitalis or other heart pills			
Diuretic or water pills			
Hormones			
Insulin or oral anti-diabetic drugs			
Iron pills			
Laxatives			
Morphine			
Nitroglycerine			
Pain killers (aspirin, empirin, anacin, bufferin, etc.)			
Pep pills or Mood elevators			
Pills to lower your blood pressure			
Sleeping pills			
Sulfa preparations			
Thyroid medication			
Tranquilizers, sedatives, or nerve pills			
Vitamins			
Others			

HISTORY OF HOSPITALIZATION: Have you ever been hospitalized?

No Yes (If yes, list reason(s) and date(s) of hospitalization.)

Do you have any problems you would like to discuss with the doctor?

No Yes (If yes, please list them):

SIGNATURE AND DATE COMPLETED

(Mo.) (Day) (Yr.)