Attachment - Benzene Questionnaire

Name _____ SS# _____ Date _____

Location _____ Supervisior. _____

Department _____ Shift _____

Have you ever had exposure to benzene? ☐ Yes ☐ No

Have you ever had exposure to pesticides? ☐ Yes ☐ No

Have you ever had exposure to radiation? (other than x-rays in a doctor's office) ☐ Yes ☐ No

Have you ever had exposure to nitrates (TNT)? ☐ Yes ☐ No

If yes to any of the above questions, how much exposure did you have and when did it occur?

Have you or any members of your family had any of the following conditions?

a. Anemia (low blood, low red cell count, low iron, or sickle cell disease) ☐ Yes ☐ No

b. Leukopenia (low white cell count) ☐ Yes ☐ No

c. Thrombocytopenia (low platelet count) ☐ Yes ☐ No

d. Pancytopenia (low red cell, white cell, and platelet counts) ☐ Yes ☐ No

e. Hemophilia (abnormal blood clotting) ☐ Yes ☐ No

f. Leukemia or Lymphoma (cancer of the blood or lymph glands) ☐ Yes ☐ No

g. Any other form of cancer ☐ Yes ☐ No

If yes to any of the above, please list the dates of illness and the treatment received, if any.

Please list all prescription and non-prescription medications that you have taken in the past 30 days.

Have you had any disease or disorder of the kidneys or liver? ☐ Yes ☐ No
If yes, please give date of illness and describe.

Have you had any disease or disorder of the heart or lungs? ☐ Yes ☐ No
If yes, please give date of illness and describe.

Have you had any of the following symptoms in the past 30 days?

a. Dizziness ☐ Yes ☐ No

b. Excessive fatigue ☐ Yes ☐ No

c. Bleeding from the gums or inside of mouth ☐ Yes ☐ No

d. Frequent or easy bruising ☐ Yes ☐ No

e. Rapid heart rate with normal activities ☐ Yes ☐ No

f. Shortness of breath with normal activities ☐ Yes ☐ No

If yes to any of the above, please indicate when the problem started and whether you have seen a doctor for it.

Are there any other medical problems that you would like to discuss with the doctor?

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