Medical Evaluation Questionnaire for Occupational Lead Exposure

By the Massachusetts Division of Occupational Safety
modified by Elizabeth O'Brien, The LEAD Group Inc, November 2010

Name:_____

Nationality: _____

Country of Birth: _____

Medicare / Medicaid / Social Security #_____

Date of birth:_____

Male _____ Female _____

Employer: _____

Employer's address:_____

_____

Contact person: _____

Phone: _____

Address to send results to: _____

_____

Phone: _____

Other employer(s) in past year: _____

_____

Exposure History

Past lead-related employers and hobbies (dates / years worked, country):

PO Box 161 Summer Hill NSW 2130 Australia Ph: (02) 9716 0014, Fax: (02) 9716 9005,
Email www.lead.org.au/cu.html Web:www.lead.org.au/

_____

_____

_____

Description of current job: _____

_____

Job tasks in past year (check all that apply)

_____Ironwork: cutting/burning/welding painted surfaces or lead-containing scrap metal

_____Painting / brushing with lead paint____ Spray painting with lead paint

_____paint applications: applying lead paint as a powder

_____Lead paint containment: erecting/removing barriers or covers

_____paint removal: __dry scraping __chemical removal __power sanding

_____burning _____ abrasive blasting

_____cleanup: ___sweeping ___standard vacuum ___HEPA vacuum

_____Battery manufacturing / recycling

_____Lead soldering ____Lead smelting _____ Foundry work

_____Radiator repair _____Metal machining or grinding

_____Wire or cable manufacture _____Plastics / PVC manufacture

_____Scrap metal recycling_____Ammunition manufacture

_____Demolition_____Other lead work (specify)_____

Other possible current or recent exposures:

____Leadlighting / Stained glass ____ Pottery /ceramics ____ Folk medicines:

_____Ayurvedic medicine_____Chinese herbal medicine_____Other (specify)_____

____Firing range use or maintenance ____Making bullets or shot

_____Making fishing sinkers_____Home or other building renovation

_____Furniture or mirror renovation_____Burning painted wood

_____Home car maintenance_____Home auto paint renovation

_____Regular use of hair colour restorer or other leaded cosmetics

_____Regular use of pewter for_____food or _____drink. Specify the food or drink and the frequency:_____

_____Regular use of crystal for_____food or _____drink. Specify the food or drink and the frequency:_____

_____Regular ingestion of turmeric. Specify frequency: _____

_____Regular ingestion of imported canned foods (specify)_____

_____Regular ingestion of Chinese preserved eggs. Specify frequency: _____

Comments (eg favourite foods if unusual): _____

_____

Protective measures

Respirator: (check those used) _____Dust mask (disposable)

_____Standard canister (negative-pressure) respirator

_____Negative-pressure respirator, with HEPA filter

_____Powered air-purifying respirator

_____Supplied-air respirator

Have you been fitted for respirator and trained in its uses? ____Yes ____No

Have you had any difficulty wearing a respirator? ____Yes ____No

Do you: eat or drink in the work area? ____Yes ____No

smoke in the work area? ____Yes ____No

wash your hands before eating or smoking? ____Yes ____No

wear your work clothes home? ____Yes ____No

Are facilities available for: eating in clean area? ____Yes ____No

handwashing? ____Yes ____No

showers? ____Yes ____No

laundering of work clothes by the workplace? ____Yes ____No

Do you know of others you work with who have had high lead levels? ____Yes ____No

Do your co-workers have low blood lead levels? ____Yes ____No

Have you had previous lead tests? ____Yes ____No

Dates and results, if known:_____

Have you needed treatment for lead poisoning before, or ____Yes ____No

removal from lead exposure because of a high level?

Current Symptoms Y N Comments

Weight loss _____

Fatigue _____

Poor sleep _____

Metallic taste in mouth_____

Loss of appetite _____

Abdominal pain _____

Nausea/vomiting _____

Pain in teeth _____

Constipation _____

Irritability _____

Headaches _____

Memory problems _____

Difficulty concentrating _____

Hearing loss _____

Numbness or tingling of
hands or feet _____

Joint pain _____

Change in sex drive _____

(Women) Change in
menstrual periods _____

Other _____

Past Medical History

Y N Comments

Have you ever had:

High blood pressure _____

Kidney disease _____

Anemia/low blood count _____

Heart disease _____

Asthma _____

Emphysema _____

Bronchitis _____

Gout _____

Arthritis _____

Head injury _____

Depression _____

Difficulty conceiving a child _____

A child with a birth defect
or learning disability _____

(Women) Miscarriage _____

Social and Family History

Do any children live in your home? _____Yes _____No. If Yes,

Ages, Male / Female:_____

When was your home built (if known)? _____

Is there any lead paint in it? ____Yes ____ No ____ Don't know

Do you smoke cigarettes? ____Yes ____No If Yes, packs per day

_____Brand:_____, or Bagged loose tobacco:_____

Has alcohol ever been a problem for you? _____Yes _____No

When was your last drink? _____

Physical Examination

Height_____ Weight _____ BP_____ P_____

Normal Abnormal Comment

HEENT (lead line optic disc) _____

Heart _____

Lungs _____

Abdomen _____

Cranial nerves _____

Motor strength (esp wrist extensors)_____

Sensory (esp distal) _____

Coordination _____

Affect _____

Orientation (place, person, time) _____

Memory (object recall) _____

Attention (serial 7s) _____

Visual-spatial (design copying) _____

Laboratory tests ordered:

Whole blood lead _____ ZPP _____

Hgb _____ Hct _____ MCV _____ Smear _____

BUN _____ Creat _____ U/A _____

Iron studies_____

Other _____

Optional tests: Sperm analysis _____

Pregnancy test _____

Nerve conduction velocity _____

Medical Evaluation for Lead Exposure

Results and Recommendations

(copy to employer and employee)

Name:_____ Date of birth: _____

Date of evaluation:_____

Blood lead level:_____

Any condition detected which increases risk from exposure to lead? ____Yes

____No. Specify:_____

Duty status:

_____Continued duty

_____Continued duty, but review of protective measures

_____Medical removal from lead exposure, with wage protection*

_____Medical removal and chelation therapy**

Respirator use:

_____No restrictions on use

_____Use with following accommodations: _____

_____Not approved for respirator use

Follow-up:_____Follow-up medical evaluation in _____ days / weeks***

_____Follow-up blood lead test in _____ days / weeks / months****

_____Lead test dust wipes____at workplace____at home____at hobby location

_____Blood lead test co-workers _____co-habitants_____child co-habitants

Nutritional intervention: _____