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):
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
laun(____Yes  ____No
dando 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 removal from lead exposure because of a high level?  ____Yes  ____No

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

(copies 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: ____________________________________________