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PAGES 1-4. FOR PAGES 5-8, OPEN FORM ARS-182C-B.

The Social Security Number fields have been removed from this form.

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 *(mm/dd/yyyy)*	SEX
		☐ MALE ☐ FEMALE

RACE

- ☐ BLACK/NOT HISPANIC ORIGIN
- ☐ WHITE/NOT HISPANIC ORIGIN
- ☐ HISPANIC
- ☐ ASIAN/PACIFIC ISLANDER
- ☐ AMERICAN INDIAN/ ALASKAN NATIVE
- ☐ OTHER *(specify):*

MARITAL STATUS

- ☐ SINGLE/NEVER MARRIED
- ☐ MARRIED/LIVING TOGETHER
- ☐ SEPARATED
- ☐ DIVORCED
- ☐ WIDOWED

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

STREET	APARTMENT NO.	
CITY	**STATE**	**ZIP CODE**

EMPLOYEE'S PHYSICIAN

LAST NAME	OFFICE TELEPHONE *(Include Area Code)*	
STREET ADDRESS	**SUITE NO.**	
CITY	**STATE**	**ZIP CODE**

EMPLOYEE'S CURRENT JOB

LOCATION *(City)*	STATE	ZIP CODE
REGULAR WORKPLACE *(Building and Room No.)*		**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.		

SOCIAL SECURITY NO.

EMPLOYMENT HISTORY

Start with the job you held before this one, and list **all** the jobs you ever had. Include military service and any part-time jobs:

COMPANY NAME OR TYPE OF BUSINESS	FROM MONTH/YEAR	TO MONTH/YEAR	JOB TITLE OR DESCRIPTION

SOCIAL SECURITY NO.

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?

	NO	PREVIOUSLY	CURRENTLY
Auto mechanic work			
Auto body work			
Been exposed to rubber cement for extended periods of time			
Carpentry			
Ceramics			
Etching/metal work/jewelry/metal sculpture			
Furniture refinishing			
House painting			
Lawn/Garden maintenance or farming			
Make your own cartridges/salvage spent cartridges			
Make your own fishing sinkers			
Oil painting			
Pottery			
Recreational hunting/shooting			

Do you now or have you in the past, come into contact with any of the following during your spare time?

	NO	PREVIOUSLY	CURRENTLY
Acids			
Bonding agents or industrial glues			
Cleaning fluids			
Fertilizers			
Gasoline or other petroleum products			
Herbicides or weed killers			
Insecticides/pesticides			
Insulation material			
Lacquer, varnish or enamel paints			
Leather dyes			
Paint thinners and removers			
Soldering agents			
Solvents/degreasers			
Wood stains			

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

	PRESENT	PAST		PRESENT	PAST		PRESENT	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:

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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./day

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./day

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? ☐ No ☐ Yes
(If yes, which of the following items do you restrict?)

☐ 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):*