chest pain ____

Please circle your answer.

5. Do you have any symptoms or health problems that you think may be related to your work with BD? yes no

   If yes, please describe:_____
   _____

6. Have any of your co-workers had similar symptoms or problems?
   yes no don't know

   If yes, please describe:_____
   _____

7. Do you notice any irritation of your eyes, nose, throat, lungs, or skin when working with BD?
   yes no

8. Do you notice any blurred vision, coughing, drowsiness, nausea, or headache when working with BD? yes no

9. Have you been taking any NEW medications (including birth control or over-the-counter)? yes no

   If yes, please list:

   _____ _____ _____

   _____ _____ _____

10. Have you developed any NEW allergies to medications, foods, or chemicals?
    yes no

    If yes, please list:

    _____ _____ _____

    _____ _____ _____

11. Do you have any health conditions not covered by this questionnaire that you think are affected by your work with BD? yes no

    If yes, please explain:_____
    _____

12. Did you understand all the questions? yes no

_____
Signature