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