

UNIVERSITY OF CINCINNATI
DEPARTMENT OF ENVIRONMENTAL HEALTH
W.G. KRUMMRICH PLANT
MONSANTO COMPANY

INFORMED CONSENT STATEMENT

Before agreeing to participate in this study, it is important that you understand the purpose of the examination, its benefits and possible discomforts. The objective of this examination is to determine the health status of the employees of the W.G. Krummrich plant of the Monsanto Company who have been exposed to chlorinated phenols and to identify those conditions which may be related to the work environment.

I, _____, agree to participate in the medical research study conducted by the University of Cincinnati under the direction of Dr. Raymond R. Suskind. I understand that I will be interviewed and asked a series of questions about myself and the health of my family. In addition to a physical examination, I shall permit blood to be drawn and furnish urine for laboratory examination. If indicated by the physician's examination, skin biopsies and skin scrapings for laboratory diagnosis will be done. The discomfort of the biopsy will be the same as with a skin injection.

The University of Cincinnati Medical Center follows a policy of making all decisions concerning compensation and medical treatment for injuries occurring during or caused by participation in biomedical or behavioral research on an individual basis. If I believe I have been injured as a result of research, I will contact Dr. Suskind.

Any questions that I may have concerning this study will be answered by Dr. Raymond R. Suskind, phone (513) 872-5701, or his associates

I am free to withdraw from this investigation at any time. Should I wish to withdraw, I have been assured that standard therapy for my condition will remain available to me. I have been informed of the probable as well as unpredictable consequences of my withdrawal from the study.

Subject _____

Investigator R. R. Suskind M.D.

Witness _____

Date _____

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HEALTH STATUS RESEARCH PROGRAM
UNIVERSITY OF CINCINNATI
EMPLOYEES OF THE W.G. KRUMMRICH PLANT, MONSANTO COMPANY
QUESTIONNAIRE

Name: _____
 Last First Middle

Address: _____
 Street Apt. #

 City State Zip Code

Telephone Number: _____
 area code

Social Security Number: _____

Present Status: ☐ Active hourly
(check one) ☐ Active Salary
 ☐ Other

Current Department: _____ # | | | | |

Job Title: _____ # | | | |

Clock Number: | | | |

Interviewer Number: | | |

Date of Interview: | | | | | |
 mo. day yr.

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A. PERSONAL DATA

1. Birthdate:
 mo. day yr.
2. Sex: male female
3. Race: White, not of Hispanic Origin
 Black, not of Hispanic Origin
 Hispanic
 American Indian or Alaskan Native
 Asian or Pacific Islander
 Other _____
4. Marital Status: single married divorced
 separated widowed
5. Number of Marriages:
6. Education: Highest grade completed
Elementary = 01 - 08 Secondary = 09 - 12
College = 13 (1 year)
 14 (2 years)
 15 (3 years)
 16 (4 years)
 17 (5 years)
 18 (6 years)
 19 (7 or more years)

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B. OCCUPATIONAL HISTORY

1. Were you employed in pentachlorophenol production? ☐ yes ☐ no

If yes, for how many months?

Date of leaving penta work:
mo. yr.

Job Title code

What was your main job or work:(describe)

2. If you are now in the "chlorophenol" department, when did you start?

mo. day yr.

3. What is your present job title? code

4. Beginning with your first job at the Krummrich plant, give the following information:

Department	Job Title	Dates (from/to) mo/yr/mo/yr	What you did (work description)
1.		-	
2.		-	
3.		-	
4.		-	
5.		-	
6.		-	
7.		-	

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Department	Job Title	Dates (from/to) mo/yr/mo/yr	What you did (work description)
8. _____	_____	-	_____

9. _____	_____	-	_____

10. _____	_____	-	_____

5. Previous work history, before Krummrich including Armed Forces:

Employer	Job Title	Dates (from/to) mo/yr/mo/yr	Work Description
_____	_____	-	
_____	_____	-	
_____	_____	-	
_____	_____	-	
_____	_____	-	
_____	_____	-	
_____	_____	-	
_____	_____	-	
_____	_____	-	
_____	_____	-	

6. While working at the Krummrich plant were you engaged in other employment?

a. mechanical work ☐ yes ☐ no

b. farming ☐ yes ☐ no

c. other ☐ yes ☐ no (describe _____)

7. In previous employment, were you exposed to dust, solvents, cutting oils, welding or soldering fumes, fertilizer, weed killers, etc.

☐ yes ☐ no

If yes, specify which: _____

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C. AT WORK

- | | | |
|---|-------------------------|------------------------|
| 1. Do you or did you smoke on the job? | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 2. Do you or did you eat on the job? | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 3. Do you or did you drink coffee or soft drinks on the job? | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 4. Do you or did you wear short sleeves at work? | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 5. Do you or did you wear long sleeves at work? | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 6. Have you ever worn gloves on the job?
What kind? _____
What job? _____ | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 7. Have you worn protective sleeves on the job? | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 8. Have you worn special shoes or boots other than safety shoes at work? | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 9. Have you ever used a respirator on a job?
What job? _____ | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 10. Do you or did you use special safety glasses or goggles on the job?
What job? _____ | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 11. Do you or did you use waterless hand cleaner? | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 12. Was soap supplied by the company?
What kind? _____ | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 13. Was soap supplied by you?
What kind? _____ | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 14. Do you or did you wear any protective clothing on the job like an apron or special suit?
Which? _____
What job? _____ | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 15. Do you or did you use a mask at work?
What job? _____ | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |
| 16. Do you or did you use protective creams on your skin at work?
<u> </u> <u> </u> often <u> </u> <u> </u> occasionally <u> </u> <u> </u> seldom
What brand? - _____ | <u> </u> <u> </u> yes | <u> </u> <u> </u> no |

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17. Do you or did you change out of your work clothes regularly before going home? ☐ yes ☐ no
18. Do you or did you change out of your work shoes regularly before going home? ☐ yes ☐ no
19. Where are your work clothes laundered?
☐ home ☐ company
☐ commercial laundry
20. Do you or did you shower before going home? ☐ yes ☐ no
21. Did you ever have an illness you felt was caused by your work? ☐ yes ☐ no

Describe illness: _____

What job? _____

Department _____

Type of work _____

When _____

D. TOBACCO CONSUMPTION

1. Do you presently smoke cigarettes? ☐ yes ☐ no
 If yes, total years smoking? ☐ ☐ ☐
 packs smoked per day? ☐ ☐ -1 ☐ 1-2 ☐ 2-3 ☐ 3+
2. If you do not now smoke cigarettes, have you smoked them in the past? ☐ yes ☐ no
 If yes, at what age did you start? ☐ ☐ ☐
 total years smoked? ☐ ☐ ☐
 packs smoked a day? ☐ ☐ -1 ☐ 1-2 ☐ 2-3 ☐ 3+

E. ALCOHOL CONSUMPTION

1. Do you now drink alcoholic beverages? ☐ yes ☐ no
 If no, did you ever drink alcoholic beverages? ☐ yes ☐ no
 How old were you when you gave up drinking? ☐ ☐ ☐
2. How old were you when you first started drinking? ☐ ☐ ☐

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3. About how often do you drink some kind of alcoholic beverage?

 almost every day

 three or four times a week

 once or twice a week

 once or twice a month

 less than once a month

4. When you drink beer, about how many cans or bottles of beer do you usually drink?

 0 1-2 3-4 5-6 6+

5. When you drink wine, about how many glasses of wine do you usually drink?

 0 1-2 3-4 5-6 6+

6. When you drink highballs, mixed drinks, or other kinds of liquor, about how many drinks do you usually have?

 0 1-2 3-4 5-6 6+

7. Have your drinking habits changed over time? yes no

IF YES:

8. If you reduced your alcoholic intake, indicate year. 19

9. When you drank beer, about how many cans or bottles did you usually drink?

 1-2 3-4 5-6 6+

10. When you drank wine, about how many glasses did you usually drink?

 1-2 3-4 5-6 6+

11. When you drank highballs, mixed drinks, or other kinds of liquor, how many did you usually have?

 1-2 3-4 5-6 6+

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F. FAMILY HISTORY

Have either your father, your mother, any of your brothers or sisters (including half-brothers and half-sisters), or any of your children had any of the following problems?

READ EACH PROBLEM. CHECK A "YES" OR A "NO" RESPONSE. IF "YES", CHECK THE APPROPRIATE RELATIONSHIP(S). IF "YES" FOR A BROTHER OR SISTER, ASK:

How many of your brother(s) or sister(s) have (had) this problem?

AND ENTER APPROPRIATE RESPONSE.

PROBLEM	RESPONSE	RELATIONSHIP	HOW MANY SIBLINGS/CHILDRE HAVE (HAD) THIS PROBLEM
1. Asthma	☐ yes ☐ no	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Children	☐ ☐
2. Hayfever	☐ yes ☐ no	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Children	☐ ☐
3. Acne (pimples)	☐ yes ☐ no	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Children	☐ ☐
4. Eczema	☐ yes ☐ no	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Children	☐ ☐
5. Hives	☐ yes ☐ no	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Children	☐ ☐

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G. PERSONAL MEDICAL HISTORY

1. Have you been bothered with any of the following conditions?

Headaches	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
High Blood Pressure	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Bronchitis	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Pneumonia	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Pleurisy	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Chest Pain	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Kidney Trouble	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Bladder Trouble	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Diabetes	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Thyroid Problems	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Stomach Ulcer	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Constipation	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Colitis	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Liver Problems	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Arthritis	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Teenage Acne	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Skin Boils	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Poison Ivy or Poison Oak	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Hives	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Other Rash	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Skin Cancer	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Other Forms of Cancer	<u> </u> <u> </u> yes	<u> </u> <u> </u> no

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2. Have you ever been hospitalized? yes no

IF YES, ASK:

Why were you hospitalized?

In what year were you hospitalized?

What was the name of the hospital?

Where is the hospital (in what city and state)?

CONDITION	YEAR	HOSPITAL - NAME	CITY	STATE
	19 <u> </u> <u> </u> <u> </u>			
	19 <u> </u> <u> </u> <u> </u>			
	19 <u> </u> <u> </u> <u> </u>			
	19 <u> </u> <u> </u> <u> </u>			
	19 <u> </u> <u> </u> <u> </u>			
	19 <u> </u> <u> </u> <u> </u>			

COMMENTS:

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- | | | |
|---------------------------------------|------------------------------|-----------------------------|
| 3. Do you have headaches? | ☐ yes | ☐ no |
| daily? | ☐ yes | ☐ no |
| weekly? | ☐ yes | ☐ no |
| less than weekly? | ☐ yes | ☐ no |
| 4. Do you have trouble sleeping? | ☐ yes | ☐ no |
| 5. Are you tired most of the time? | ☐ yes | ☐ no |
| 6. Do you need more sleep than usual? | ☐ yes | ☐ no |
| 7. Do you have a good appetite? | ☐ yes | ☐ no |
| 8. Do you lose your temper easily? | ☐ yes | ☐ no |
| 9. Do you feel angry often? | ☐ yes | ☐ no |

H. SOCIAL HISTORY

- | | | |
|---|--|-----------------------------|
| 1. How many times have you been married? | ☐ ☐ ☐ | |
| 2. How many children do you have? | ☐ ☐ ☐ | |
| 3. Do you have as many children as you wanted to have? | ☐ yes | ☐ no |
| 4. Did your wife have any miscarriages?
How many? | ☐ yes
☐ ☐ ☐ | ☐ no |
| 5. Were there any stillbirths? | ☐ yes | ☐ no |
| 6. Were any of the children born with any birth defects or deformities?
Indicate type of birth defect. | ☐ yes | ☐ no |

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I. MEDICATION HISTORY

1. Do you regularly use health aids such as those for constipation, indigestion, arthritis, or headache (for example aspirin, laxatives, diet pills, etc.)? ☐ yes ☐ no

If yes, what kind or brand: _____

2. Do you regularly use salves or liniments such as those for itchy skin, burns, abrasions, etc.? ☐ yes ☐ no

If yes, what kind or brand: _____

3. Do you have or have you ever had acne? ☐ yes ☐ no

If yes, how was it treated? _____

4. Are you now taking medication(s) prescribed by a doctor? ☐ yes ☐ no

If yes, specify the name(s) of the medication and the illness(es) being treated: _____

5. Do you have any known allergic reactions to drugs? ☐ yes ☐ no

If yes, to what drugs (be specific)? _____

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J. REVIEW OF SYSTEMS AND PHYSICAL EXAMINATION -

Vital Signs

Nurse ID#

Date
mo. day yr.

BP mmHg

Pulse min.

Resp. min.

5 min. BP

Height inches

Weight pounds

Temp. °F

Unusual appearance yes no

If yes, describe _____

Physician _____ Physician ID#

Additional History

Review of Systems

Physical Examination

(Indicate Problems and/or Abnormal Findings)

Skin - active or residue of acne
other skin abnormalities, nails, hair|
|
|

 yes no

 yes no

Nose, mouth, throat, mucous
membranes|
|
|

 yes no

 yes no

Eyes|
|
|

 yes no

 yes no

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Additional History
Review of Systems

Physical Examination

Lymph nodes

|
|
|

 yes no

 yes no

Other organ systems, if indicated

|
|
|

 yes no

 yes no

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Abnormal Findings

From History ☐ yes ☐ no
Detail:

From Physical Examination ☐ yes ☐ no
Detail:

Diagnosis - Impression

1.

2.

3.

4.

Comments

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LABORATORY TESTS

Please check if done:

Urine Sample	ID# <u> </u> <u> </u> <u> </u>	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Blood Sample	ID# <u> </u> <u> </u> <u> </u>	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Skin Biops.	ID# <u> </u> <u> </u> <u> </u>	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Skin Scrapings	ID# <u> </u> <u> </u> <u> </u>	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Culture	ID# <u> </u> <u> </u> <u> </u>	<u> </u> <u> </u> yes	<u> </u> <u> </u> no
Photograph	ID# <u> </u> <u> </u> <u> </u>	<u> </u> <u> </u> yes	<u> </u> <u> </u> no

OTHER TESTS:

COMMENTS:

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