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