General Survey

Form Approved
OMB No. 0923-0051
Exp. Date 10/31/2024

Interviewer___________ Household ID____________ Participant ID ____________

Date ______________ Start time ______________ End time _______________

Participant Name: ____

SECTION I: ADULT SURVEY

GENERAL SURVEY MODULE: LOCATION/EXPOSURE

From now on, I will refer to the [Description of Incident] on [Date] as "the incident."

1. I would like to know about your exposure inside the highlighted area on the map between [Incident Date] at [Time] and [End Date/Time].

a. What is the address of where you were the longest during the incident? Probe for as much location information as possible. Then, continue to b.	Street address City, State Zip Other location information
b. How long were you in this location? circle whether in minutes or hours.	_____ minutes hours
c. Did you receive instructions to shelter in place? If respondent said "yes" go to d, if "no" continue to e:	Yes No Unsure
d. Please describe what you did to shelter in place.	
e. Did you smell an odor? If no or unsure skip questions f and g.	Yes No Unsure
f. Can you please describe the odor?	☐ Gasoline ☐ Rotten eggs ☐ Chemical Smell ☐ Paint or paint thinner ☐ Bug spray ☐ Smoke ☐ Sewage ☐ Other_____
g. Would you describe the odor as light, moderate or severe?	Light Moderate Severe
h. Did you come in contact with any of the following?	☐ Smoke ☐ Dust ☐ Debris ☐ Hazardous substance ☐ Unsure ☐ Other_____

2. Did you evacuate from the highlighted area on the map?
   - ☐ Yes
   - ☐ No ➔ Go to Question 5

3. At approximately what time did you evacuate?
   _____:_____ ☐ AM ☐ PM
   Hour Min

4. How did you evacuate?
   - ☐ Ambulance
   - ☐ Privately-owned vehicle
   - ☐ Bus
   - ☐ Other (Please specify): _____

5. Were you decontaminated, meaning your clothing was removed or your body was washed?
   - ☐ Yes
   - ☐ No ➔ Go to next module

6. How were you decontaminated? Read all answer choices aloud to the respondent and check all that apply.
   - ☐ Clothing Removal
   - ☐ Water
   - ☐ Soap and Water
   - ☐ Other (Please specify): _____

7. Where were you decontaminated? If respondent needs clarification, specify that this question is asking for a geographic location, not a place on their body. Read all choices to the respondent.
   - ☐ Community reception center (CRC)
   - ☐ Mobile decontamination unit
   - ☐ Emergency room (ER)
   - ☐ Other (Please specify): _____

8. At approximately what time were you decontaminated?
   _____:_____ ☐ AM ☐ PM
   Hour Min

Participant ID: _____

General Survey Module: Health Status after the Incident

1. I'm going to ask you some questions about symptoms that could be related to the [Incident]. This list should be narrowed down ahead of time with a toxicologist or physian or other expert. Fill out the table provided below. Completei-iii for one symptom before asking about the next symptom.

	i. Did you experience [Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom.		ii. If you experienced this [Symptom] before the incident did it get worse?		iii. Are you still experiencing [Symptom]? Repeat i for next symptom.	
Symptom	Yes	No	Yes	No	Yes	No
GENERAL						
1.1 Fever						
1.2 Chills						
1.3 Generalized weakness						
1.4 Body pain						
1.5 Severe bleeding						
EYES						
2.1 Increased tearing						
2.2 Irritation/pain/ burning of eyes						
2.3 Blurred vision/double vision						
2.4 Bleeding in eyes						
EAR/NOSE/THROAT						
3.1 Runny nose						
3.2 Burning nose or throat						
3.3 Nose Bleeds						
3.4 Hoarseness						
3.5 Increased salivation						
3.6 Ringing in ears						
3.7 Difficulty swallowing						
3.8 Swollen neck						
3.9 Pain in jaw						

	i. Did you experience [Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom.		ii. If you experienced this [Symptom] before the incident did it get worse?		iii. Are you still experiencing [Symptom]? Repeat i for next symptom.	
Symptom	Yes	No	Yes	No	Yes	No
3.10 Odor on breath (Gasoline or other, specify)						
3.11 Stuffy nose/sinus congestion						
3.12 Increased congestion or phlegm						
NERVOUS SYSTEM						
4.1 Headache						
4.2 Dizziness or lightheadedness						
4.3 Loss of consciousness/fainting						
4.4 Seizures or convulsions						
4.5 Numbness, pins and needles, or funny feeling in arms or legs						
4.6 Confusion						
4.7 Difficulty concentrating						
4.8 Difficulty remembering things						
4.9 Concussion						
4.10 Loss of balance						
MUSCLE/JOINT/BONES						
5.1 Weakness of arms						
5.2 Weakness of legs						
5.3 Joint swelling						
5.4 Muscle weakness						
5.5 Muscle twitching						
5.6 Tremors in arms or legs						

	i. Did you experience [Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom.		ii. If you experienced this [Symptom] before the incident did it get worse?		iii. Are you still experiencing [Symptom]? Repeat i for next symptom.	
Symptom	Yes	No	Yes	No	Yes	No
5.7 Joint pain						
5.8 Broken bone/fracture						
5.9 Dislocation						
5.10 Sprain or strain						
5.11 Whiplash						
HEART AND LUNGS						
6.1 Breathing slow						
6.2 Breathing fast						
6.3 Difficulty breathing/feeling out-of-breath						
6.4 Coughing						
6.5 Wheezing in chest						
6.6 Slow heart rate/pulse						
6.7 Fast heart rate/pulse						
6.8 Chest tightness or pain/angina						
6.9 Bronchitis						
6.10 Pneumonia						
6.11 Burning lungs						
STOMACH/INTESTINES						
7.1 Nausea						
7.2 Non-bloody vomiting						
7.3 Non-bloody diarrhea						
7.4 Bloody vomiting						
7.5 Blood in stool/diarrhea						
7.6 Abdominal pain						
7.7 Fecal incontinence or inability to control bowel movements						

	i. Did you experience [Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom.		ii. If you experienced this [Symptom] before the incident did it get worse?		iii. Are you still experiencing [Symptom]? Repeat i for next symptom.	
Symptom	Yes	No	Yes	No	Yes	No
7.8 Bowel perforation						
SKIN						
8.1 Irritation, pain, or burning of skin						
8.2 Skin rash						
8.3 Hives						
8.4 Skin blisters						
8.5 Bumps containing pus						
8.6 Nail changes						
8.7 Hair loss in area of rash						
8.8 Hair loss						
8.9 Dry or itchy skin						
8.10 Sweating						
8.11 Cool or pale skin						
8.12 Skin discoloration						
8.13 Poor wound healing						
8.14 Petechiae/Pinpoint round spots						
8.15 Blue coloring of ends of fingers/toes or lips						
8.16 Lips turning blue						
8.17 Abrasion/scrape						
8.18 Bruise						
8.19 Cut						
KIDNEY/BLADDER						
9.1 Urinary incontinence or dribbling pee						
9.2 Inability to urinate or pee						
9.3 Blood in urine						

	i. Did you experience [Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom.		ii. If you experienced this [Symptom] before the incident did it get worse?		iii. Are you still experiencing [Symptom]? Repeat i for next symptom.	
Symptom	Yes	No	Yes	No	Yes	No
9.4 Painful urine						
PSYCHIATRIC						
10.1 Anxiety						
10.2 Agitation/irritability						
10.3 Thoughts of suicide						
10.4 Fatigue/tiredness						
10.5 Difficulty sleeping						
10.6 Difficulty staying asleep						
10.7 Feeling depressed						
10.8 Hallucinations						
10.9 Paranoia						
10.10 Unexplained fear						
10.11 Tension or nervousness						
Any other symptoms? If yes, What was it? Record below.						
1.						
2.						
3.						
4.						

Participant ID: _____

General Survey Module: Optional Mental Health Screeners

Generalized Anxiety Disorder 7 (GAD 7)

Over the last 2 weeks, how often have you been bothered by the following symptoms?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being too restless that it is hard to sit still	0	1	2	3
6. Being easily annoyed or irritable	0	1	2	3
7. Feeling as though something awful might happen	0	1	2	3

Generalized Anxiety Disorder 7 (GAD7) Scoring System

GAD-7 Score	Level of Anxiety
0 – 4	Minimal
5 – 9	Mild
10 – 14	Moderate
15 – 21	Severe

Participant ID: _____

Screening Questionaire for Disaster Mental Health (SQD)

People who have experienced the incident often report that their lives have changed dramatically and they are constantly under various kinds of stress. Have you experienced any of the symptoms listed below in the past month?

Q1. Have you noticed any changes in your appetite? 1. Yes 0. No

Q2. Do you feel that you are easily tired and/or tired all the time? 1. Yes 0. No

Q3. Do you have trouble falling asleep or sleeping through the night? 1. Yes 0. No

Q4. Do you have nightmares about the event? 1. Yes 0. No

Q5. Do you feel depressed? 1. Yes 0. No

Q6. Do you feel irritable? 1. Yes 0. No

Q7. Do you feel that you are hypersensitive to small noises or tremors? 1. Yes 0. No

Q8. Do you avoid places, people, topics related to the event? 1. Yes 0. No

Q9. Do you think about the event when you do not want to? 1. Yes 0. No

Q10. Do you have trouble enjoying things you used to enjoy? 1. Yes 0. No

Q11. Do you get upset when something reminds you of the event? 1. Yes 0. No

Q12. Do you notice that you are making an effort to try not to think about the event, or are trying to forget it? 1. Yes 0. No

[Score]

SQD-P: Q3 + Q4 + Q6 + Q7 + Q8 + Q9 + Q10 + Q11 + Q12 = _____

SQD-D: Q1 + Q2 + Q3 + Q5 + Q6 + Q10 = _____

[Guidelines]

SQD-P: 9-6 = Severely affected (possible Acute Stress Disorder (ASD))

5-4 = Moderately affected

3-0 = Slightly affected (currently little possibility of ASD)

SQD-D: 6-5 = More likely to be depressed

4-0 = Less likely to be depressed

Participant ID: _____

General Survey Module: Medical Care

1. Did you receive medical care or a medical evaluation because of the incident?
   - ☐ Yes ➔ Go to Question 3
   - ☐ No

2. Why didn't you seek medical care?
   - ☐ Did not have symptoms
   - ☐ Symptoms were not bad enough
   - ☐ Don't like to go to the doctor
   - ☐ Didn't want to take time
   - ☐ Worried about who would pay for the medical visit
   - ☐ Worried about losing job
   - ☐ Other (Please specify): _____
   - ☐ Unsure

For those individuals who did not seek medical care, go to the next module.

3. Please tell me if any of the following describe why you sought medical care. Read questions a-c to the respondent and circle the appropriate answer(s).

a. You were given instructions to seek medical care?	Yes	No	Unsure
b. You experienced health problems or symptoms within 24 hours of the incident?	Yes	No	Unsure
c. You were worried about possible health problems associated with the incident?	Yes	No	Unsure

4. How did you receive medical care Can Check more than 1?
   - ☐ EMT or paramedic
   - ☐ Hospital ➔ Go to Question 5
   - ☐ Doctor or other medical professional ➔ Go to Question 15

5. On what date were you first provided care at a hospital? If you had any additional visits to the hospital, please provide me the dates of those visits. Record the date that the respondent first went to the hospital and then the date of any subsequent visits.

1st date of hospital visit: _____/_____/_____
MM DD YYYY

2nd date of hospital visit: _____/_____/_____
MM DD YYYY

3rd date of hospital visit: _____/_____/_____
MM DD YYYY

6. What is the name and city of the hospital(s)?

   Hospital 1_____City 1 _____

   Hospital 2 _____City 2_____

   Hospital 3 _____City 3_____

7. How did you get to the hospital? If the respondent had more than one hospital visit, tell them that you are referring to their first visit.
   - ☐ EMS/Ambulance
   - ☐ Drove self
   - ☐ Driven by relative, friend, or acquaintance
   - ☐ Other (Please specify): _____

8. Were you treated only in the emergency department or were you admitted to the hospital?
   - ☐ Treated in emergency department (Outpatient) ➔ Go to Question 15
   - ☐ Admitted (Hospitalized)

9. How many nights were you hospitalized, including any nights in an intensive care unit (ICU)?
   _____ Nights

10. Were you placed in an Intensive Care Unit or ICU?
    - ☐ Yes
    - ☐ No ➔ Go to Question 15

11. How many nights were you in the ICU?
    _____ Nights

12. Were you on a ventilator?
    - ☐ Yes
    - ☐ No ➔ Go to Question 15

13. How many nights were you on a ventilator?
    _____ Nights

14. If aged 18 or older, read: To improve future responses, we try to study medical emergency response as thoroughly as possible. Are you willing to let us get a copy of your medical records for the medical treatment you received because of the incident?

☐ Yes ➔ Review the medical records release form with the respondent and collect their signature

☐ No

15. Read i–iv to the respondent and record information in the table below.

i. On what dates were you provided care by a doctor or other medical professional? (mm/dd/yyyy)	ii. What is the name of the doctor or other medical professional?	iii. What service did this doctor or medical professional provide?	iv. What is the address of the office?

Participant ID: _____

General Survey Module: Medical History

Now I'm going to ask you a few questions about illnesses you may have had and the kinds of medicines you may have used.

1. Prior to the incident, have you ever been told by a doctor or other health care provider that you have or had any of the following medical conditions? You can narrow down the table below in consultation with a toxicologist or physician if these conditions do not seem relevant to the exposures. Fill out the table below. Circle appropriate response and ask the respondent to specify as directed.

Medical Condition	
a. Allergies?	Yes (Please specify) _____ No Unsure
b. Asthma?	Yes No Unsure
c. Depression?	Yes No Unsure
d. Anxiety?	Yes No Unsure
e. Diabetes?	Yes No Unsure
f. High blood pressure?	Yes No Unsure
g. Chronic obstructive pulmonary disease (COPD) or emphysema?	Yes No Unsure
h. Heart Disease?	Yes No Unsure
i. Physical disability that hinders mobility?	Yes (Please specify)_____ No Unsure
j. Psychological condition such as anxiety, depression or dependence disorder?	Yes (Please specify) _____ No Unsure

Medical Condition	
k. Cancer?	Yes (Please specify) _____ No Unsure
l. Immune disorders such as lupus, rheumatoid arthritis, or HIV?	Yes No Unsure
m. Neurological conditions such as Parkinson's disease or multiple sclerosis?	Yes No Unsure
n. Any other medical conditions?	Yes (Please specify) _____ No Unsure

2. Prior to the incident, were you taking any medication? This includes medication prescribed by a health care provider and those you might have gotten without a prescription from stores, pharmacies, friends, or relatives.

☐ Yes
☐ No
☐ Don't Know

3. Do you currently smoke cigarettes, cigars, or pipes?

☐ Yes
☐ No
☐ Don't Know/Refuse to answer

→ Go to Question F6

4. Have you smoked on a daily basis in the past?

☐ Yes
☐ No
☐ Don't Know/Refuse to answer

5. On average, how many of that product do you currently smoke each day?
Please specify: _____

If respondent is male, go to next module

6. Are you currently pregnant?
   - ☐ Yes
   - ☐ No
   - ☐ Don't Know

7. Are you currently breastfeeding?
   - ☐ Yes
   - ☐ No

Participant ID: _____

General Survey Module: Occupation

1. Are you currently employed. This includes part-time and full-time jobs that lasted one month or more, such as jobs for pay inside or outside the home or jobs on a farm?
   - ☐ Yes
   - ☐ No skip to next module

2. What is your occupation? *If unknown probe for a specific description of their main duties*_____

3. Who is your employer? Probe for company name and city _____

4. Did you respond in any way to this incident <u>If yes and necessary, probe.</u>
   - ☐ Yes
   - ☐ Not a responder ➔ **<u>Go to next module</u>**

2. Are you a volunteer or career responder?
   - ☐ Volunteer
   - ☐ Career responder

3. At the time of the incident, how long had you been working in that role? (e.g., firefighter, police, recovery worker etc.)

   _____ Years _____ Months

4. Prior to incident, were you trained to respond to an incident of this nature?
   - ☐ Yes
   - ☐ No

5. Were you trained on PPE usage, including types and how to properly don/remove your PPE?
   - ☐ Yes
   - ☐ No

6. Is PPE readily available to you?
   - ☐ Yes
   - ☐ No
   - ☐ Unsure

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7. Please look at this list and tell me what level of PPE you were wearing when you responded to the incident

If Responder type Volunteer firefighter through Company Responder ask . Present Showcard Side A.

- ☐ None
- ☐ Level "A"
- ☐ Level "B"
- ☐ Level "C"
- ☐ Level "D"
- ☐ Firefighter turn-out gear with respiratory protection.
- ☐ Firefighter turn-out gear without respiratory protection.
- ☐ Other types of protection (such as gloves, eye protection, hardhat, steel-toed shoes)
  If selected, ask: Please specify the type of protection:

_____

If Responder type is Hospital worker or EMS worker or other ask Present Showcard Side B

- ☐ None
- ☐ Non-sterile exam gloves
- ☐ Surgical gloves
- ☐ Face mask without protective shield
- ☐ Face mask with protective shield
- ☐ Non-splash resistant disposable gown
- ☐ Splash resistant disposable gown
- ☐ Protective eye glasses/goggles
- ☐ Supplied air respirator
- ☐ Respirator with cartridge/HEPA filters
- ☐ Other-specify the type of protection: _____

8. Did you need to stay home from work or miss work due to symptoms you experienced after the incident?

☐ Yes **Ask** how many days did you miss?_____days
☐ No
☐ Unsure

9. Did you need to modify your regular work duties due to symptoms you experienced after the incident?

☐ Yes **Ask** how many days of modified work duties did you need?_____days
☐ No
☐ Unsure

10. What, if anything, could have been done differently to improve the response?

_____
_____
_____

Participant ID: _____

GENERAL SURVEY MODULE: COMMUNICATION AND NEEDS

Now I would like to ask you a few questions about the communication you may have received regarding the incident.

Fill in the table below. Ask i and only check the box next to the type of information the respondent received first. Then follow-up with ii-iii for the information the respondent received first. Then continue to next table.

Source of Information	i. How did you first receive information about the incident? Check only one box.	**ii How soon after incident did you receive instructions (minutes)? Was the information** Minutes	**iii.Was the information Sufficient/helpful sufficient/helpful? Write yes, no, or DK (for don't know)**
Directly from person in authority (i.e. police, firefighter, Hazmat official, supervisor)			
TV			
Radio			
Two-way radio			
Newspaper			
Relative/friend/neighbor/ coworker			
Website			
Social Media			
Reverse 911 call			
Phone call			
Text message on a cell phone			
Email			
Community Meeting			
Other, Specify:			

Ask i and only check the box next to the type of follow-up information the respondent received. Then ask ii-iii for each information source before moving to the next source.

Source of Information	i. How did you receive follow-up information about the incident? Check all that apply.	ii.How soon after incident did you receive instructions (minutes)	iii.Was the information sufficient/helpful? Write yes, no, or DK (for don't know)
Directly from person in authority (i.e. police, firefighter, Hazmat official, supervisor)			
TV			
Radio			
Two-way radio			
Newspaper			
Relative/friend/neighbor/ coworker			
Website			
Social Media			
Reverse 911 call			
Phone call			
Text message on a cell phone			
Email			
Community Meeting			
Other, Specify:			

2. In the future, what are the best ways for your local authorities or the health department to reach you with information regarding an incident? Check all that apply:

- ☐ TV
- ☐ Radio
- ☐ Newspaper
- ☐ Website
- ☐ Social Media
- ☐ Phone call
- ☐ Text message on a cell phone
- ☐ Email
- ☐ Community meeting
- ☐ Other (Please specify): _____

3. As a result of this incident, are you personally in need of anything? (check all that apply)

- ☐ Medicine or medical supplies
- ☐ Medical care
- ☐ Mental health care
- ☐ Water
- ☐ Shelter
- ☐ Food
- ☐ Utilities
- ☐ Transportation
- ☐ Other, specify _____
- ☐ Don't know/refused

4. What is your current address?

Street _____ Apt _____

City _____ State __ __ Zip Code: _____

5. What is the best telephone number to reach you? Please specify if this is a cellular phone, house phone, or work phone.

(__ __ __) __ __ __ - __ __ __ __

- ☐ Cell
- ☐ House
- ☐ Work

6. Are there any more telephone numbers where you can be reached?

If yes, collect all other numbers and specify whether cell, house, or work number.

(__ __ __) __ __ __ - __ __ __ __

- ☐ Cell
- ☐ House
- ☐ Work

7. Do you have an email address where you can be reached?

- ☐ Yes
- ☐ No➔ Go to Q8

What is your email address?

_____

8. We may want to interview you again in the future to check up on your health. Keeping in mind that people move, we would like to get a little more

information to help us locate you in the future. In case you move to another residence, could we have the name and contact information of a person who live outside of your household and who would always know how to find you?

☐ Yes ➔ Complete the table provided

☐ No ➔ Go to next module

	Person 1
First and Last Name	
Address	
Phone Number (including area code)	
Email Address	
Relationship to you (parent, child, sibling, other relative, friend, other)	

Participant ID: _____

General Survey Module: Exposure of Other People Present

1. Were there any other individuals present with you in the highlighted area of the map during the incident? Show highlighted area of the map.
   ☐ Yes
   ☐ No ➔ Go to next module

2. In order to accurately evaluate the impact of the incident, we are trying to interview as many people who were in the area as possible. Fill in the following table with the information given for Question a-c.
   a. Can you tell me the names of everyone else who was present with you during the incident?
   b. Which are children, and what are their ages?
   c. Can you tell me the phone number and e-mail address of the people who do not live with you?

Name	Age (if child)	Phone	E-mail

Participant ID: _____

General Survey Module: Demographic and Contact Information

Now, I have some general questions about you.

1. Do you identify as male, female, or other?

☐ Male
☐ Female
☐ Other

2. What is your date of birth?

____/____/_____
MM DD YYYY

3. Do you consider yourself to be Hispanic or Latino?

☐ Yes
☐ No
☐ Refused or unknown

4. What race do you consider yourself to be?

Check all that apply:

☐ Black or African American
☐ White
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander

5. What is the highest level of education you completed?

☐ Grade 8 or Less
☐ Some High School
☐ High School Graduate or Equivalent
☐ Some University/College
☐ Technical or Trade School
☐ Junior or Community College
☐ University/College Graduate
☐ Graduate School or Higher

CONCLUSION STATEMENTS

1. Is there anything that we did nto cover that you want to tell us related to the incident?

   _____
   _____
   _____
   _____
   _____
   _____
   _____

2. If Exposure of Other People Present Module did not identify children under the age of 13 that were present, go to Closing Statement. If children under the age of 13 were identified, read: I would now like to ask you some questions regarding any children you have under the age of 13 that were with you when you were in the highlighted areas of the map.

   Refer to Exposure of Other People Present Module to recall child's name and then go to the Child Survey Section

Closing Statement:

That completes this survey. I would like to sincerely thank you for your time. Be sure to record the end time on the first page of this survey.

Participant ID: _____

Child's Name: _____ Participant ID _____

CHILD SURVEY MODULE: LOCATION/EXPOSURE

1. Did [Child's name] evacuate from the highlighted area on the map?
   - ☐ Yes
   - ☐ No

2. At approximately what time did he/she evacuate?

   _____:_____ ☐ AM ☐ PM
   Hour Min

3. How did he/she evacuate?
   - ☐ Ambulance
   - ☐ Privately-owned vehicle
   - ☐ Bus
   - ☐ Other (Please specify): _____

   _____

4. Was [Child's name] decontaminated, meaning their clothing was removed or their body was washed?
   - ☐ Yes
   - ☐ No ➔ Go to next module

5. How was [Child's name] decontaminated? Read all answer choices aloud to the respondent and check all that apply.
   - ☐ Clothing Removal
   - ☐ Water
   - ☐ Soap and Water
   - ☐ Other (Please specify): _____

6. Where was [Child's name] decontaminated? If respondent needs clarification, specify that this question is asking for a geographic location, not a place on their body. Read all choices to the respondent.

   - ☐ Community reception center (CRC)
   - ☐ Mobile decontamination unit
   - ☐ Emergency room (ER)
   - ☐ Other (Please specify): _____

7. At approximately what time was [Child's name] decontaminated?
   _____:_____ ☐ AM ☐ PM

Participant ID: _____

Child Survey Module: Health Status after the Incident

I'm going to ask some questions about symptoms that could be related to the [Incident]. Fill out the table provided below. Check the boxes that apply before asking about the next symptom.

	i. Did [Child's name] experience [Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom.		ii. If [Child's name] experienced this [Symptom] before the incident did it get worse?		iv. Is [Child's name] still experiencing [Symptom]? Repeat i for next symptom.	
	Yes	No	Yes	No	Yes	No
GENERAL						
1.6 Fever						
1.7 Chills						
1.8 Generalized weakness						
1.9 Body pain						
1.10 Severe bleeding						
EYES						
2.5 Increased tearing						
2.6 Irritation/pain/ burning of eyes						
2.7 Blurred vision/double vision						
2.8 Bleeding in eyes						
EAR/NOSE/THROAT						
3.13 Runny nose						
3.14 Burning nose or throat						
3.15 Nose Bleeds						
3.16 Hoarseness						
3.17 Increased salivation						
3.18 Ringing in ears						
3.19 Difficulty swallowing						
3.20 Swollen neck						

	i. Did [Child's name] experience [Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom.		ii. If [Child's name] experienced this [Symptom] before the incident did it get worse?		iv. Is [Child's name] still experiencing [Symptom]? Repeat i for next symptom.	
	Yes	No	Yes	No	Yes	No
3.21 Pain in jaw						
3.22 Odor on breath (Gasoline or other, specify)						
3.23 Stuffy nose/sinus congestion						
3.24 Increased congestion or phlegm						
NERVOUS SYSTEM						
4.11 Headache						
4.12 Dizziness or lightheadedness						
4.13 Loss of consciousness/fainting						
4.14 Seizures or convulsions						
4.15 Numbness, pins and needles, or funny feeling in arms or legs						
4.16 Confusion						
4.17 Difficulty concentrating						
4.18 Difficulty remembering things						
4.19 Concussion						
4.20 Loss of balance						
MUSCLE/JOINT/BONES						
5.12 Weakness of arms						
5.13 Weakness of legs						
5.14 Joint swelling						
5.15 Muscle weakness						
5.16 Muscle twitching						

	i. Did [Child's name] experience [Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom.		ii. If [Child's name] experienced this [Symptom] before the incident did it get worse?		iv. Is [Child's name] still experiencing [Symptom]? Repeat i for next symptom.	
	Yes	No	Yes	No	Yes	No
5.17 Tremors in arms or legs						
5.18 Joint pain						
5.19 Broken bone/fracture						
5.20 Dislocation						
5.21 Sprain or strain						
5.22 Whiplash						
HEART AND LUNGS						
6.12 Breathing slow						
6.13 Breathing fast						
6.14 Difficulty breathing/feeling out-of-breath						
6.15 Coughing						
6.16 Wheezing in chest						
6.17 Slow heart rate/pulse						
6.18 Fast heart rate/pulse						
6.19 Chest tightness or pain/angina						
6.20 Bronchitis						
6.21 Pneumonia						
6.22 Burning lungs						
STOMACH/INTESTINES						
7.9 Nausea						
7.10 Non-bloody vomiting						
7.11 Non-bloody diarrhea						
7.12 Bloody vomiting						
7.13 Blood in stool/diarrhea						
7.14 Abdominal pain						

	i. Did [Child's name] experience [Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom.		ii. If [Child's name] experienced this [Symptom] before the incident did it get worse?		iv. Is [Child's name] still experiencing [Symptom]? Repeat i for next symptom.	
	Yes	No	Yes	No	Yes	No
7.15 Fecal incontinence or inability to control bowel movements						
7.16 Bowel perforation						
SKIN						
8.20 Irritation, pain, or burning of skin						
8.21 Skin rash						
8.22 Hives						
8.23 Skin blisters						
8.24 Bumps containing pus						
8.25 Nail changes						
8.26 Hair loss in area of rash						
8.27 Hair loss						
8.28 Dry or itchy skin						
8.29 Sweating						
8.30 Cool or pale skin						
8.31 Skin discoloration						
8.32 Poor wound healing						
8.33 Petechiae/Pinpoint round spots						
8.34 Blue coloring of ends of fingers/toes or lips						
8.35 Lips turning blue						
8.36 Abrasion/scrape						
8.37 Bruise						
8.38 Cut						
KIDNEY/BLADDER						
9.5 Urinary incontinence or dribbling pee						

	i. Did [Child's name] experience [Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom.		ii. If [Child's name] experienced this [Symptom] before the incident did it get worse?		iv. Is [Child's name] still experiencing [Symptom]? Repeat i for next symptom.	
	Yes	No	Yes	No	Yes	No
9.6 Inability to urinate or pee						
9.7 Blood in urine						
9.8 Painful urine						
PSYCHIATRIC						
10.12 Anxiety						
10.13 Agitation/irritability						
10.14 Thoughts of suicide						
10.15 Fatigue/tiredness						
10.16 Difficulty sleeping						
10.17 Difficulty staying asleep						
10.18 Feeling depressed						
10.19 Hallucinations						
10.20 Paranoia						
10.21 Unexplained fear						
10.22 Tension or nervousness						
Any other symptoms? If yes, What was it? Record below.						
1.						
2.						
3.						
4.						

Participant ID: _____

CHILD SURVEY MODULE: MEDICAL CARE

1. Did [Child's name] receive medical care or evaluation because of the incident?
   - ☐ Yes ➔ Go to Question 3
   - ☐ No

2. Why didn't you seek medical care for [Child's name]?
   - ☐ Did not have symptoms
   - ☐ Symptoms were not bad enough
   - ☐ Don't like to go to the doctor
   - ☐ Didn't want to take time
   - ☐ Worried about who would pay for the medical visit
   - ☐ Worried about losing job
   - ☐ Other (Please specify):

     _____
   - ☐ Unsure

For those individuals who did not seek medical care for the child, go to the next module.

3. Please tell me if any of the following describe why [Child's name] sought medical care. Read questions a-c to the respondent and circle the appropriate answer(s).
   a. You were given instructions to seek medical care? ..... Yes No Unsure
   b. You experienced health problems or symptoms within 24 hours of the incident? ..... Yes No Unsure
   c. You were worried about possible health problems associated with the incident? ..... Yes No Unsure

4. How did [Child's name] receive medical care?
   - ☐ EMT or paramedic
   - ☐ Hospital ➔ Go to Question 5
   - ☐ Doctor or other medical professional ➔ Go to Question 14

5. On what date was [Child's name] first provided care at a hospital? If he/she had any additional visits to the hospital, please provide me the dates of those visits. Record the date that the child first went to the hospital and then the date of any subsequent visits.

   1st date of hospital visit: _____/_____/_____ (MM DD YYYY)

   2nd date of hospital visit: _____/_____/_____ (MM DD YYYY)

   3rd date of hospital visit: _____/_____/_____ (MM DD YYYY)

6. What is the name and city and state of the hospital(s)?
   Hospital Name 1 _____HCity 1_____HState 1__ __
   Hosptal Name 2_____HCity 2_____HState2 __ __
   Hospital Name 3_____HCity 3_____HState3__ __

7. How did [Child's name] get to the hospital? If the child had more than one hospital visit, tell the respondent that you are referring to the child's first visit.
   - ☐ EMS/Ambulance
   - ☐ Driven by relative, friend, or acquaintance
   - ☐ Other (Please specify): _____

8. Was [Child's name] treated only in the emergency department or was he/she admitted to the hospital?
   - ☐ Treated in an emergency department (Outpatient) ➔ Go to Question 14
   - ☐ Admitted (Hospitalized)

9. How many nights was he/she hospitalized, including any nights in an intensive care unit (ICU)?
   _____Nights

10. Was he/she placed in an Intensive Care Unit or ICU?
    - ☐ Yes
    - ☐ No ➔ Go to Question 14

11. How many nights was he/she in the ICU?
    _____ Nights

12. Was he/she on a ventilator?
    - ☐ Yes
    - ☐ No ➔ Go to Question 14

13. How many nights was he/she on a ventilator?
    _____ Nights

14. Read i–iv to the respondent and record information in the table below.

v. On what dates was [Child's name] provided care by a doctor or other medical professional? (mm/dd/yyyy)	vi. What is the name of the doctor or medical professional?	vii. What service did this doctor or medical professional provide?	iii. What is the address of the office?

Participant ID: _____

CHILD SURVEY MODULE: MEDICAL HISTORY

Now I'm going to ask you a few questions about illnesses your child may have had and the kinds of medicines he/she may have used.

1. Prior to the incident, have you ever been told by a doctor or other health care provider that [Child's name] has any of the following medical conditions? Fill out the table below. Circle appropriate response and ask the respondent to specify as directed.

Medical Condition	
a. Allergies?	Yes (Please specify) _____ No Unsure
b. Asthma?	Yes No Unsure
c. Depression?	Yes No Unsure
d. Anxiety?	Yes No Unsure
e. Diabetes?	Yes No Unsure
f. High blood pressure?	Yes No Unsure
g. Chronic obstructive pulmonary disease (COPD) or emphysema?	Yes No Unsure
h. Heart Disease?	Yes No Unsure
i. Physical disability that hinders mobility?	Yes (Please specify)_____ No Unsure
j. Psychological condition such as anxiety, depression or dependence disorder?	Yes (Please specify) _____ No Unsure
k. Cancer?	Yes (Please specify) _____ No Unsure
l. Immune disorders such as lupus, rheumatoid arthritis, or HIV?	Yes

Medical Condition	
	No Unsure
m. Neurological conditions such as Parkinson's disease or multiple sclerosis?	Yes No Unsure
n. Any other medical conditions?	Yes (Please specify) _____ No Unsure

Prior to the incident, was [Child's name] taking any medication? This includes medication prescribed by a health care provider and those you might have gotten without a prescription from stores, pharmacies, friends, or relatives.

☐ Yes
☐ No
☐ Don't Know

Participant ID: _____

CHILD SURVEY MODULE: DEMOGRAPHIC INFORMATION

Now, I have some general questions about [Child's name].

1. Does [Child's name] identify as male, female, or other?
   - ☐ Male
   - ☐ Female
   - ☐ Other

2. What is [Child's name] date of birth?
   ____/____/_____
   MM DD YYYY

1. Do you consider [Child's name] to be Hispanic or Latino?
   - ☐ Yes
   - ☐ No

2. What race do you consider him/her to be?
   Check all that apply:
   - ☐ Black or African American
   - ☐ White
   - ☐ Asian
   - ☐ American Indian or Alaska Native
   - ☐ Native Hawaiian or Other Pacific Islander

3. What is [Child's name] current address?
   Street _____ Apt _____
   City _____ State __ __ Zip Code: _____

Participant ID: _____

CHILD SURVEY MODULE: CONCLUDING INSTRUCTIONS

If there are more children under age 13, get a new child survey and ask about next child.

Closing Statement:

That completes this survey. I would like to sincerely thank you for your time. Be sure to record the end time on the first page of this survey.