Household Survey Sample

Form Approved
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Interviewer_____ Household ID_____

Date _____ Start time _____ End time _____

Cluster/Zone _____ Latitude _____ Longitude _____

Type of residence

☐ Single family ☐ Multiple unit ☐ Mobile home ☐ Other _____

HOUSEHOLD SURVEY

MODULE: CONTACT INFORMATION

1. What is your full name?

   _____

2. What is your street address?

   Street _____ Apt _____

   City _____ State __ __ Zip Code: _____

3. What is the best telephone number to reach you in case we have questions about your survey? Please specify if this is a cellular phone, house phone, or work phone.

   (__ __ __) __ __ __ - __ __ __ __ ☐ Cell ☐ House ☐ Work

MODULE: DEMOGRAPHICS

1. How many people live in this residence? _____

   How many are male? _____ How many are female? _____

2. How many people that live here are less than two years old? _____

   2–17 years old? _____ 18–64 years old? _____ More than 64 years old? _____

3. How many people in this household are of Hispanic, Latino, or Spanish origin? _____

4. To which race do members of this household most identify? I will read a list of races. Please tell me how many people in the household identify as being that race.
   Record the number of people of each race described:

   _____ Black _____ American Indian/Alaska Native

   _____ White _____ Native Hawaiian or other Pacific Islander

   _____ Asian

Household ID: _____

MODULE: LOCATION/EXPOSURE AND COMMUNICATIONS

1. Was anyone home at any time between [Incident Date/Time] and [End Date/Time]?
   - ☐ Yes
   - ☐ No

2. After [the incident] did you or anyone else in your household detect any unusual smells or tastes that you think were related to the incident?
   - ☐ Yes
   - ☐ No

3. Did you or anyone else in your household shelter in place, meaning staying inside, with doors and windows closed and all ventilation systems turned off? If yes, ask the respondent: Where did you shelter in place? ☐ At home ☐ At work ☐ At school ☐ In your vehicle ☐ Other(Please specify):	Yes No Unsure
4. Did you follow instructions about shelter in place?	Yes No Unsure
5. Did you or anyone else in your household smell an odor? If no or unsure skip questions I and j.	Yes No Unsure
6. Can you please describe the odor? ☐ Gasoline ☐ Rotten eggs ☐ Chemical Smell ☐ Paint or paint thinner ☐ Bug spray ☐ Smoke ☐ Sewage ☐ Other(Please specify):	
7. Would you describe the odor as light, moderate or severe?	Light Moderate Severe
8. Did you or anyone else in your household come in contact with? ☐ Smoke cloud ☐ Dust ☐ Debris ☐ Fog	

☐ Other(Please specify): ☐ Unsure	

9. How did your family first receive information or instructions about the incident? Check only one.

☐ Noticed odor/saw chemical
☐ Directly from person in authority (police, firefighter)
☐ Reverse 911 call to landline phone
☐ Reverse 911 call to cell phone
☐ Call to landline phone
☐ Call to cell phone
☐ TV
☐ Radio
☐ Text message on a cell phone
☐ Social media (Facebook, Twitter)
☐ Directly from another person (such as friend or relative)
☐ Other (Please specify):_____

10. As the incident progressed, how did you obtain information? Check all that apply.

☐ Directly from person in authority (police, firefighter)
☐ Reverse 911 call to landline phone
☐ Reverse 911 call to cell phone
☐ Call to landline phone
☐ Call to cell phone
☐ TV
☐ Radio
☐ Text message on a cell phone
☐ Social media
☐ Website
☐ Community meeting
☐ Newspaper
☐ Directly from another person (such as friend or relative)
☐ Other (Please specify):_____

11. Did your household evacuate after [the incident]?

☐ Yes
☐ No ➔ Go to Question D1

12. Which day and at approximately what time did you evacuate?

_____/_____/_____ _____:_____ ☐ AM ☐ PM
MM DD YYYY

Household ID: _____

MODULE: HEALTH STATUS

1. I'm going to ask you some questions about symptoms that could be related to the [Incident]. The appropriate symptoms for the incident should be selected ahead of time. Fill out the table provided below for each one.

	i. Did anyone in your household experience [Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom.		ii. If anyone in your household experienced this [Symptom] before the incident did it get worse?		iii. Is anyone in your household still experiencing [Symptom]? Repeat i for next 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						

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	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						

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	Yes	No	Yes	No	Yes	No
5.6 Tremors in arms or legs						
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						

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	Yes	No	Yes	No	Yes	No
7.7 Fecal incontinence or inability to control bowel movements						
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						

	i. Did anyone in your household experience [Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom.		ii. If anyone in your household experienced this [Symptom] before the incident did it get worse?		iii. Is anyone in your household still experiencing [Symptom]? Repeat i for next symptom.	
	Yes	No	Yes	No	Yes	No
9.2 Inability to urinate or pee						
9.3 Blood in urine						
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.						

Household ID: _____

MODULE : MEDICAL CARE RECEIVED

1. Did you or anyone in your family 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. For each person who received medical care, please tell me the person's name, where they received care, and the date. Please include medical evaluations by emergency medical services or EMTs, hospitals, and doctor's offices.

Name	**Where Received Care**	**Date**

5. If a hospital was named, ask: Was [name] treated and released from the emergency department or hospitalized? If hospitalized, ask: How long was [he/she] hospitalized?

Name	Treated and Released	Hospitalized	Duration of Hospitalization

MODULE: NEEDS

1. As a result of the incident, does your household need any of the following…
   Read all choices to the respondent.

   (check all that apply)

   - ☐ Medicine or medical supplies
   - ☐ Medical care
   - ☐ Mental health care
   - ☐ Water
   - ☐ Shelter
   - ☐ Food
   - ☐ Utilities
   - ☐ Transportation
   - ☐ Other, specify _____

   ☐ Don't know/refused

MODULE: OTHER INFORMATION

1. Is there anything else you want to tell us related to the [chemical] incident?

_____

_____

_____

_____

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.