Form Approved

OMB No. 0923-0051

Exp. Date 10/31/2024

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:

1. 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? ­­­­­\_\_\_\_\_

1. 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? \_\_\_\_\_

1. How many people in this household are of Hispanic, Latino, or Spanish origin? ­­­­\_\_\_\_\_
2. 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

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS E-11 Atlanta, Georgia 30333; ATTN: PRA (0923-0051)

**Module: Location/Exposure and Communications**

1. Was anyone home at any time between [Incident Date/Time] and [End Date/Time]?

Yes

No

1. 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

|  |  |
| --- | --- |
| 1. 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 |
| 1. Did you follow instructions about shelter in place? | Yes No Unsure |
| 1. Did you or anyone else in your household smell an odor? If no or unsure skip questions I and j. | Yes No Unsure |
| 1. Can you please describe the odor?   Gasoline  Rotten eggs  Chemical Smell  Paint or paint thinner  Bug spray  Smoke  Sewage  Other(Please specify): |  |
| 1. Would you describe the odor as light, moderate or severe? | Light Moderate Severe |
| 1. Did you or anyone else in your household come in contact with?   Smoke cloud  Dust  Debris  Fog  Other(Please specify):  Unsure |  |

1. 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):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Yes

No Arrow pointing to instructions following the response Go to Question D1

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

\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ \_\_\_\_:\_\_\_\_\_ AM PM

MM DD YYYY

**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.

|  | 1. Did anyone in your household experience[Symptom] **since the incident**? If yes, go to ii. If no, repeat i for next symptom. | | 1. If anyone in your household experienced this [Symptom] before the incident did it get worse? | | 1. Is anyone in your household still experiencing [Symptom]? Repeat i for next symptom. | |
| --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No | Yes | No | Yes | No |
|  |  |  |  |  |  |  |
| **GENERAL** |  |  |  |  |  |  |
| 1. Fever |  |  |  |  |  |  |
| 1. Chills |  |  |  |  |  |  |
| 1. Generalized weakness |  |  |  |  |  |  |
| 1. Body pain |  |  |  |  |  |  |
| 1. Severe bleeding |  |  |  |  |  |  |
| **EYES** |  |  |  |  |  |  |
| 1. Increased tearing |  |  |  |  |  |  |
| 1. Irritation/pain/ burning of eyes |  |  |  |  |  |  |
| 1. Blurred vision/double vision |  |  |  |  |  |  |
| 1. Bleeding in eyes |  |  |  |  |  |  |
| **EAR/NOSE/THROAT** |  |  |  |  |  |  |
| 1. Runny nose |  |  |  |  |  |  |
| 1. Burning nose or throat |  |  |  |  |  |  |
| 1. Nose Bleeds |  |  |  |  |  |  |
| 1. Hoarseness |  |  |  |  |  |  |
| 1. Increased salivation |  |  |  |  |  |  |
| 1. Ringing in ears |  |  |  |  |  |  |
| 1. Difficulty swallowing |  |  |  |  |  |  |
| 1. Swollen neck |  |  |  |  |  |  |
| 1. Pain in jaw |  |  |  |  |  |  |
| 1. Odor on breath (Gasoline or other, specify) |  |  |  |  |  |  |
| 1. Stuffy nose/sinus congestion |  |  |  |  |  |  |
| 1. Increased congestion or phlegm |  |  |  |  |  |  |
| **NERVOUS SYSTEM** |  |  |  |  |  |  |
| 1. Headache |  |  |  |  |  |  |
| 1. Dizziness or lightheadedness |  |  |  |  |  |  |
| 1. Loss of consciousness/fainting |  |  |  |  |  |  |
| 1. Seizures or convulsions |  |  |  |  |  |  |
| 1. Numbness, pins and needles, or funny feeling in arms or legs |  |  |  |  |  |  |
| 1. Confusion |  |  |  |  |  |  |
| 1. Difficulty concentrating |  |  |  |  |  |  |
| 1. Difficulty remembering things |  |  |  |  |  |  |
| 1. Concussion |  |  |  |  |  |  |
| 1. Loss of balance |  |  |  |  |  |  |
| **MUSCLE/JOINT/BONES** |  |  |  |  |  |  |
| 1. Weakness of arms |  |  |  |  |  |  |
| 1. Weakness of legs |  |  |  |  |  |  |
| 1. Joint swelling |  |  |  |  |  |  |
| 1. Muscle weakness |  |  |  |  |  |  |
| 1. Muscle twitching |  |  |  |  |  |  |
| 1. Tremors in arms or legs |  |  |  |  |  |  |
| 1. Joint pain |  |  |  |  |  |  |
| 1. Broken bone/fracture |  |  |  |  |  |  |
| 1. Dislocation |  |  |  |  |  |  |
| 1. Sprain or strain |  |  |  |  |  |  |
| 1. Whiplash |  |  |  |  |  |  |
| **HEART AND LUNGS** |  |  |  |  |  |  |
| 1. Breathing slow |  |  |  |  |  |  |
| 1. Breathing fast |  |  |  |  |  |  |
| 1. Difficulty breathing/feeling out-of-breath |  |  |  |  |  |  |
| 1. Coughing |  |  |  |  |  |  |
| 1. Wheezing in chest |  |  |  |  |  |  |
| 1. Slow heart rate/pulse |  |  |  |  |  |  |
| 1. Fast heart rate/pulse |  |  |  |  |  |  |
| 1. Chest tightness or pain/angina |  |  |  |  |  |  |
| 1. Bronchitis |  |  |  |  |  |  |
| 1. Pneumonia |  |  |  |  |  |  |
| 1. Burning lungs |  |  |  |  |  |  |
| **STOMACH/INTESTINES** |  |  |  |  |  |  |
| 1. Nausea |  |  |  |  |  |  |
| 1. Non-bloody vomiting |  |  |  |  |  |  |
| 1. Non-bloody diarrhea |  |  |  |  |  |  |
| 1. Bloody vomiting |  |  |  |  |  |  |
| 1. Blood in stool/diarrhea |  |  |  |  |  |  |
| 1. Abdominal pain |  |  |  |  |  |  |
| 1. Fecal incontinence or inability to control bowel movements |  |  |  |  |  |  |
| 1. Bowel perforation |  |  |  |  |  |  |
| **SKIN** |  |  |  |  |  |  |
| 1. Irritation, pain, or burning of skin |  |  |  |  |  |  |
| 1. Skin rash |  |  |  |  |  |  |
| 1. Hives |  |  |  |  |  |  |
| 1. Skin blisters |  |  |  |  |  |  |
| 1. Bumps containing pus |  |  |  |  |  |  |
| 1. Nail changes |  |  |  |  |  |  |
| 1. Hair loss in area of rash |  |  |  |  |  |  |
| 1. Hair loss |  |  |  |  |  |  |
| 1. Dry or itchy skin |  |  |  |  |  |  |
| 1. Sweating |  |  |  |  |  |  |
| 1. Cool or pale skin |  |  |  |  |  |  |
| 1. Skin discoloration |  |  |  |  |  |  |
| 1. Poor wound healing |  |  |  |  |  |  |
| 1. Petechiae/Pinpoint round spots |  |  |  |  |  |  |
| 1. Blue coloring of ends of fingers/toes or lips |  |  |  |  |  |  |
| 1. Lips turning blue |  |  |  |  |  |  |
| 1. Abrasion/scrape |  |  |  |  |  |  |
| 1. Bruise |  |  |  |  |  |  |
| 1. Cut |  |  |  |  |  |  |
| **KIDNEY/BLADDER** |  |  |  |  |  |  |
| 1. Urinary incontinence or dribbling pee |  |  |  |  |  |  |
| 1. Inability to urinate or pee |  |  |  |  |  |  |
| 1. Blood in urine |  |  |  |  |  |  |
| 1. Painful urine |  |  |  |  |  |  |
| **PSYCHIATRIC** |  |  |  |  |  |  |
| 1. Anxiety |  |  |  |  |  |  |
| 1. Agitation/irritability |  |  |  |  |  |  |
| 1. Thoughts of suicide |  |  |  |  |  |  |
| 1. Fatigue/tiredness |  |  |  |  |  |  |
| 1. Difficulty sleeping |  |  |  |  |  |  |
| 1. Difficulty staying asleep |  |  |  |  |  |  |
| 1. Feeling depressed |  |  |  |  |  |  |
| 1. Hallucinations |  |  |  |  |  |  |
| 1. Paranoia |  |  |  |  |  |  |
| 1. Unexplained fear |  |  |  |  |  |  |
| 1. Tension or nervousness |  |  |  |  |  |  |
| Any other symptoms? If yes, What was it? Record below. |  |  |  |  |  |  |
| 1. |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |
| 4. |  |  |  |  |  |  |

**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

1. 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.

1. 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).
   1. You were given instructions to seek medical care? Yes No Unsure
   2. You experienced health problems or symptoms   
      within 24 hours of the incident? Yes No Unsure
   3. You were worried about possible health   
      problems associated with the incident? Yes No Unsure
2. 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** |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. 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.