Attachment 5

Post-exposure Questionnaire

Form Approved
OMB No. 0920-0527
Exp. Date

POST WATER ACTIVITY SURVEY

Thank you for coming back for the second part of our study for today.
Now I'm going to ask what kinds of activities you have been doing here today.

Total time in water (min)	Swim	Water ski	Jet ski	Fish	Did you put your head under the water?	Did you swallow any water?	Other: Describe
	Y N DK R	Y N DK R	Y N DK R	Y N DK R	Y N DK R	Y N DK R	

Great and thanks. Now, I'd like to go over the symptom questions with you again and I'd like to tell me what symptoms you have now.

Interviewer Initials:_____

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
First I have some general health questions.			
Fever Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Chills Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Headache Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Sore throat Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Ear ache Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Discharge or fluid running from ear			

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Abdominal pain Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Nausea Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Vomiting Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Diarrea Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Diarrhea with blood Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Other (specify)_____ Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
Now, I have a few questions about eye symptoms			
Blurred Vision Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Irritation or pain Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Redness or discharge from eyes Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Conjunctivitis Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Other eye problems (specify)_____ Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R

Now I have a few questions about breathing-related symptoms

Cough or choke Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
Shortness of breath Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Nasal congestion or runny nose Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Throat irritation Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Other (specify) _____ Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R

Thank you. Now, I have some questions about problems you might have with your nerves

Agitation Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Confusion Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Dizziness Y N	DK R	DK R	Y N

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
DK R	____/____/ ____ DD MM YY	____/____/ ____ DD MM YY	DK R
Lethargy Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Loss of consciousness Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Weakness Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Seizures Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Numbness Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R
Tremor Y N DK R	DK R ____/____/ ____ DD MM YY	DK R ____/____/ ____ DD MM YY	Y N DK R

Great. Now, just a few questions about skin problems.

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
Itchy skin Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Red skin Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Hives or welts Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Skin irritation/pain Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Rash (describe) _____ Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Infected cuts or scrapes Y N DK R	DK R ____/____/____ DD MM YY	DK R ____/____/____ DD MM YY	Y N DK R
Other (specify) _____ Y N DK	DK R ____/____/____	DK R ____/____/____	Y N DK R

Symptom or Problem	When did it start?	When did it end?	Do you still have the symptom or problem?
R	DD MM YY	DD MM YY	

Thank you.

END OF ON-SITE SURVEY!