

**Attachment 5**

**Post-exposure Questionnaire**

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	

Public reporting burden for this collection of information is estimated to average 15 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; Paperwork Reduction Project (0920-0527); M.S. D-24; 1600 Clifton Road NE, Atlanta, Ga. 30333

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
Diarrhea 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)_____	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)_____	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  ____/____/ 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?
R	DD MM YY	DD MM YY	

Thank you.

END OF ON-SITE SURVEY!