

Environmental Questions

EQ1. For this study, we will be collecting some environmental samples in your home.

EQ2. Is the tap water in your home from a private well?

- YES..... 1
- NO..... 2
- REFUSED..... 9--97
- DON'T KNOW..... 9--98

EQ3. Do you have any non-electric appliances in your home? We are interested in things like a stove or oven, furnace, water heater, dryer or a gas, oil, or kerosene space heater.

- YES..... 1 (EQ007)
- NO..... 2 (EQ007)
- REFUSED..... 9--97 (EQ007)
- DON'T KNOW..... 9--98

EQ4. Can you show me your stove and your heating system if it is accessible?

DATA COLLECTOR INSTRUCTION : RECORD WHETHER THE STOVE OR HEATING SYSTEM APPEAR TO BE GAS.

	<u>YES</u>	<u>NO</u>	<u>ACCESSIBLE</u>	<u>RF</u>	<u>DK</u>
a. GAS/FUEL HEAT?.....	1	2	3	9--97	9--98
b. GAS/STOVE/OVEN?.....	1	2	3	9--97	9--98

EQ5. Is this a single family home?

- YES, SINGLE FAMILY HOME..... 1
- NO, MULTI-FAMILY HOME..... 2
- REFUSED..... 9--97
- DON'T KNOW..... 9--98

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Public reporting burden for this collection of information is estimated to average 5 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: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-xxxx*). Do not return the completed form to this address.



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National Children's Study Dwelling Unit Visual Observations

P1, T1-1st, T3-1st

Staff ID:

Time Started: : AM PM

Time Ended: : AM PM

Questions for Participant

- Bedrooms in home:
- Bathrooms in home: # FULL BATHS # HALF BATHS
- Can you show me the room where you sleep most of the time? TAKE VACUUM SAMPLE IN THIS ROOM
- Can you show me the surface of the bed on which you sleep? By surface, I mean on which blanket or sheet do you sleep directly on top? VACUUM THIS SURFACE FOR BED PORTION OF SAMPLE
- Can you show me the room you use the most? (IF SHE RESPONDS THAT SHE USES THE KITCHEN THE MOST, ASK HER FOR THE NEXT MOST USED ROOM)

Appliance Use

TECHNICIAN INSTRUCTIONS: MARK ALL APPLIANCES SP REPORTS HAVING IN HER HOME. IF THE APPLIANCE IS PRESENT, ASK THE FREQUENCY OF USE, THEN INSPECT THE VENTING AND THE PILOT LIGHT.

Do you have any of the following ...?	# in DU	Frequency of use: 1 = Daily 2 = Every other day 3 = 2 times a week 4 = < 2 times a week	# Vented	# Cont. pilot
6. <input type="checkbox"/> Dehumidifier	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	NA	NA
7. <input type="checkbox"/> Humidifier	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	NA	NA
8. <input type="checkbox"/> Air cleaning device, Type(s): Mark all. 2 <input type="checkbox"/> Electrostatic precipitator 3 <input type="checkbox"/> Ozone generator 4 <input type="checkbox"/> Filter 6 <input type="checkbox"/> Other, Brand: _____ Model #: _____	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	NA	NA
9. <input type="checkbox"/> Gas stovetop or range top:	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK
10. <input type="checkbox"/> Gas oven (include convection ovens):	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK



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Appliance Use

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Do you have any of the following ...?	# in DU	Frequency of use: 1 = Daily 2 = Every other day 3 = 2 times a week 4 = < 2 times a week	# Vented	# Cont. pilot
11. <input type="checkbox"/> Gas or fuel furnace:	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK
12. Any special ventilation systems: 1 <input type="checkbox"/> Fresh air / heat exchanger 6 <input type="checkbox"/> _____	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK
13. <input type="checkbox"/> Gas hot water heater:	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK
14. Dryer: <input type="checkbox"/> Electric	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	NA
<input type="checkbox"/> Gas	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK
15. <input type="checkbox"/> Propane/ kerosene/ gas space heater:	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK
16. <input type="checkbox"/> Gas fireplace or stove:	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK
17. <input type="checkbox"/> Wood/pellet-burning fireplace/stove:	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK
18. <input type="checkbox"/> Coal-burning stove:	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK
19. <input type="checkbox"/> OTHER COMBUSTION SOURCE: _____	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK	<input type="text"/> ₈ <input type="checkbox"/> DK

Product Use

TECHNICIAN INSTRUCTIONS: MARK IF THE PRODUCTS ARE PRESENT IN THE HOME. IF THE PRODUCT IS PRESENT ASK THE SP ABOUT THE FREQUENCY OF USE.

Mark all.	Frequency of use: 1 = Daily 3 = 2 times a week 2 = Every other day 4 = < 2 times a week
20. <input type="checkbox"/> Scented candles	<input type="text"/> ₈ <input type="checkbox"/> DK
21. <input type="checkbox"/> Unscented candles	<input type="text"/> ₈ <input type="checkbox"/> DK
22. <input type="checkbox"/> Incense	<input type="text"/> ₈ <input type="checkbox"/> DK
23. <input type="checkbox"/> Room air fresheners, e.g., Plug-ins, stick-ups	<input type="text"/> ₈ <input type="checkbox"/> DK
24. <input type="checkbox"/> Other scented household products: _____	<input type="text"/> ₈ <input type="checkbox"/> DK



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General Dwelling Unit Observations

24. Level lowest living area in DU (0=basement):

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25. DU floor:

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 NA (single family home)

26. General structural condition of DU:
1 Good (Go to 28) 2 Fair 3 Poor

27. Why condition not *good*:

- 1 Cracks on walls
- 2 Loose flooring, steps, rails, etc.
- 3 Paint chipping, peeling, etc.
- 4 Worn carpet
- 6 _____

28. Exit doors sealed tightly:
1 Yes 2 No 8 Don't know

29. Window weatherproofing: **Mark all.**

- 1 Double pane 4 None
- 2 Storm windows 6 _____
- 3 Shrink film

30. Home cleanliness:

- 1 Very clean (Go to 32) 3 Not clean
- 2 Mod. clean

31. Source of non-cleanliness: **Mark all.**

- 1 Dust 4 Stained carpet
- 2 Grime/grease 5 Animal hair
- 3 Food 6 _____

32. Household clutter:

- 1 Little 2 Mod. cluttered 3 Very cluttered

33. Evidence of cigarettes/smoking: 1 Yes 2 No

34. Observed type of heating system: **Mark all.**

- 1 None 4 Space heaters
- 2 Forced air (vents) 6 _____
- 3 Radiators (any type)

35. Comments: 1 None 6 _____

