Appendix H

NIOSH-Administered Questionnaire

(Building Related Asthma Research in Public Schools)
(New)

Form
Approved
OMB No.

NIOSH-Administered Questionnaire

Identification and Demographic Information

1. Survey Date: __ __/__ __/2008

2. Name: _____ _____ _____
First MI Last

3. Home Address: _____
(Number, Street, and/or Rural Route)

_____ _____ _____
(City) (State) (Zip Code)

4. Home Telephone Number: (__ __ __) __ __ __ - __ __ __ __

5. Date of Birth: __ __ / __ __ / __ __ __ __
Month Day Year

6. Gender: 1.____ Male
2.____ Female

7. Ethnicity (Please choose one):
1.____ Hispanic or Latino
0.____ Not Hispanic or Latino

8. Race (Please choose all that apply):
1.____ American Indian or Alaska Native
2.____ Asian
3.____ Black or African American
4.____ Native Hawaiian or Other Pacific Islander
5.____ White

Health Symptoms

9.1 During the past 12 months have you had wheezing or whistling in your chest at any time? 1.Yes ___ 0.No ___

IF YES:

9.2 Have you had wheezing or whistling in your chest one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

9.3 When you were away from the school was the wheezing or whistling:
1.Same ___ 2.Worse ___ 3.Better ___

9.4 In what month and year did you first have wheezing or whistling in your chest? __ __ / __ __ __ __
Month Year

10.1 During the past 12 months have you had chest tightness? 1.Yes ___ 0.No ___

IF YES:

10.2 Have you had chest tightness one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

10.3 When you were away from the school was the chest tightness:
1.Same ___ 2.Worse ___ 3.Better ___

10.4 In what month and year did you first have chest tightness? __ __ / __ __ __ __
Month Year

11.1 During the past 12 months have you had shortness of breath? 1.Yes ___ 0.No ___

IF YES:

11.2 Have you had shortness of breath one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

11.3 When you were away from the school was the chest tightness:
1.Same ___ 2.Worse ___ 3.Better ___

11.4 In what month and year did you first have chest tightness? __ __ / __ __ __ __
Month Year

12.1 During the past 12 months have you had a cough? 1.Yes ___ 0.No ___

IF YES:

12.2 Have you had cough one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

12.3 When you were away from the school was the cough:
1.Same ___ 2.Worse ___ 3.Better ___

12.4 In what month and year did you first have this cough? __ __ / __ __ __ __
Month Year

13.1 During the past 12 months have you been awakened by an attack of breathing difficulty? 1.Yes ___ 0.No ___

IF YES:

13.2 Have you been awakened by an attack of breathing difficulty one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

13.3 When you were away from the school was the awakening by attacks of breathing difficulty: 1.Same ___ 2.Worse ___ 3.Better ___

13.4 In what month and year were you first awakened by an attack of breathing difficulty? __ __ / __ __ __ __ Month Year

14.1 During the past 12 months, have you had shortness of breath when hurrying on level ground or walking up a slight hill? 1.Yes ___ 0.No ___

IF YES:

14.2 Have you had shortness of breath when hurrying on level ground or walking up a slight hill one or more times per week in the past 4 weeks? 1.Yes ___ 0.No ___

14.3 When you were away from the school was this shortness of breath: 1.Same ___ 2.Worse ___ 3.Better ___

14.4 In what month and year did you first have this shortness of breath? __ __ / __ __ __ __ Month Year

15.1 During the past 12 months have you had cough with phlegm? 1.Yes ___ 0.No ___

IF YES:

15.2 Have you had cough with phlegm one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

15.3 When you were away from the school was the cough with phlegm: 1.Same ___ 2.Worse ___ 3.Better ___

15.4 In what month and year did you first have cough with phlegm? __ __ / __ __ __ __ Month Year

16.1 During the past 12 months have you had episodes of fever and chills? 1.Yes ___ 0.No ___

IF YES:

16.2 Have you had episodes of fever and chills one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

16.3 When you were away from the school were these episodes of fever and chills: 1.Same ___ 2.Worse ___ 3.Better ___

16.4 In what month and year did you first have episodes of fever and chills? __ __ / __ __ __ __ Month Year

17.1 During the past 12 months have you had episodes of flu-like achiness or achy joints? 1.Yes ___ 0.No ___

IF YES:

17.2 Have you had episodes of flu-like achiness or achy joints one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

17.3 When you were away from the school was the flu-like achiness or achy joints: 1.Same ___ 2.Worse ___ 3.Better ___

17.4 In what month and year did you first have episodes of flu-like achiness or achy joints? __ __ / __ __ __ __ Month Year

18.1 During the past 12 months have you had unusual tiredness, fatigue, or drowsiness? 1.Yes ___ 0.No ___

IF YES:

18.2 Have you had unusual tiredness, fatigue, or drowsiness one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

18.3 When you were away from the school was the unusual tiredness, fatigue, or drowsiness: 1.Same ___ 2.Worse ___ 3.Better ___

18.4 In what month and year did you first have unusual tiredness, fatigue, or drowsiness? __ __ / __ __ __ __ Month Year

19.1 During the past 12 months have you had difficulty remembering things or concentrating? 1.Yes ___ 0.No ___

IF YES:

19.2 Have you had difficulty remembering things or concentrating one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

19.3 When you were away from the school was the difficulty remembering things or concentrating: 1.Same ___ 2.Worse ___ 3.Better ___

19.4 In what month and year did you first have difficulty remembering things or concentrating? __ __ / __ __ __ __ Month Year

20.1 During the past 12 months have you had dizziness or lightheadedness? 1.Yes ___ 0.No ___

IF YES:

20.2 Have you had dizziness or lightheadedness one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

20.3 When you were away from the school was the dizziness or lightheadedness: 1.Same ___ 2.Worse ___ 3.Better ___

20.4 In what month and year did you first have dizziness or lightheadedness? __ __ / __ __ __ __ Month Year

21.1 During the past 12 months have you had headaches? 1.Yes ___ 0.No ___

IF YES:

21.2 Have you had headaches one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

21.3 When you were away from the school were the headaches: 1.Same ___ 2.Worse ___ 3.Better ___

22.1 During the past 12 months have you had any episodes of stuffy, itchy or runny nose? 1.Yes ___ 0.No ___

IF YES:

22.2 Have you had a stuffy, itchy or runny nose one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

22.3 When you were away from the school was the stuffy, itchy or runny nose: 1.Same ___ 2.Worse ___ 3.Better ___

23.1 During the past 12 months have you had sneezing? 1.Yes ___ 0.No ___

IF YES:

23.2 Have you had sneezing one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

23.3 When you were away from the school was the sneezing: 1.Same ___ 2.Worse ___ 3.Better ___

24.1 During the past 12 months have you had dry or itchy skin? 1.Yes ___ 0.No ___

IF YES:

24.2 Have you had dry or itchy skin one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

24.3 When you were away from the school was the dry or itchy skin: 1.Same ___ 2.Worse ___ 3.Better ___

24.4 In what month and year did you first have dry or itchy skin? __ __ / __ __ __ __
Month Year

25.1 During the past 12 months have you had any episodes of watery, itchy eyes? 1.Yes ___ 0.No ___

IF YES:

25.2 Have you had watery or itchy eyes one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

25.3 When you are away from the school were the watery or itchy eyes: 1.Same ___ 2.Worse ___ 3.Better ___

25.4 In what month and year did you first have watery or itchy eyes? __ __ / __ __ __ __
Month Year

26.1 During the past 12 months have you had a sore or dry throat? 1.Yes ___ 0.No ___

IF YES:

26.2 Have you had sore or dry throat one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

26.3 When you are away from the school was the sore or dry throat:
1.Same ___ 2.Worse ___ 3.Better ___

26.4 In what month and year did you first have a sore or dry throat? __ __ / __ __ __ __
Month Year

27.1 During the past 12 months have you had a cold? 1.Yes ___ 0.No ___

IF YES:

27.2 Have you had a cold in the last 4 weeks? 1.Yes ___ 0.No ___

27.3 How many times have you had a cold in the last 12 months? _____Times

28.1 During the past 12 months have you had sinusitis or sinus problems? 1.Yes ___ 0.No ___

IF YES:

28.2 Have you had sinusitis or sinus problems in the last 4 weeks? 1.Yes ___ 0.No ___

28.3 How many episodes of sinusitis or sinus problems have you had in the last 12 months? _____Times

28.4 When you were away from the school were the sinusitis or sinus problems:
1.Same ___ 2.Worse ___ 3.Better ___

29.1 During the past 12 months have you had bronchitis? 1.Yes ___ 0.No ___

IF YES:

29.2 Was it confirmed by a doctor? 1.Yes ___ 0.No ___

29.3 Have you had bronchitis in the last 4 weeks? 1.Yes ___ 0.No ___

29.4 How many times have you had bronchitis in the last 12 months? _____Times

30.1 Has a physician ever told you that you have asthma? 1. Yes ___ 0. No ___

IF YES:

30.2 Date of asthma diagnosis: __ __ / __ __ __ __
Month Year

30.3 Do you still have asthma? 1. Yes ___ 0. No ___

30.4 In the last 12 months, how many times did you get treatment for an acute asthma attack at a doctor's office, urgent care facility, or emergency department (ER)? _____Times

30.5 In the last 12 months, how many times were you hospitalized overnight for asthma? _____Times

31.1 In the past 12 months, how many days have you missed work because of respiratory health problems? _____ Days

32.1 In the past 12 months, how many days have you missed work because of health problems other than respiratory? _____ Days

Medications for Breathing Problems

33.1 In the last 4 weeks have you used any prescription or over-the-counter medications for breathing problems?

1.Yes ___ 0.No ___

IF YES, PLEASE ANSWER QUESTIONS 34-39. IF NO, PLEASE GO TO QUESTION 40.1.

34.1 In the last 4 weeks, have you used any inhaled beta-agonists (quick-relief medicine, such as Albuterol or Proventil) for breathing problems? 1.Yes ___ 0.No ___

If yes:

34.2 Have you used your beta-agonist inhaler on a daily basis in the last ***4 weeks***?

1.Yes ___ 0.No ___

35.1 In the last 4 weeks, have you used any over-the-counter inhalers or pills (*e.g. Primatene*) for breathing problems? 1.Yes ___ 0.No ___

If yes to 34.1 AND/OR 35.1:

36.1 In the last 4 weeks, was your use of beta-agonist inhalers or over-the-counter medications different on weekends, days off, or vacations as compared to workdays? 1.Yes ___ 0.No ___ *If yes:*

36.2 Did you use these inhalers or pills more or less on weekends, days off, or vacations?

1.More ___ 0.Less ___

37.1 Over the last 4 weeks, have you used any inhaled corticosteroids for breathing problems?
1.Yes ___ 0.No ___

If yes:

37.2 This next question consists of two parts. First, we would like to know which inhaled corticosteroid(s) you are currently using. Second, how many puffs or inhalations per day you have taken over the last 4 weeks. (*check all that apply*)

Drug	☑	**No. of puffs/inh per day, on average, taken in the last 4 weeks**
Beclovent (*beclomethasone*) 42 mcg		
Beclovent (*beclomethasone*) 84 mcg		
Vanceril (*beclomethasone*) 42 mcg		
Vanceril (*beclomethasone*) 84 mcg		
Pulmicort (*budesonide*) 200 mcg		
Dexacort (*dexamethasone*) 84 mcg		
Aerobid (*flunisolide*) 250 mcg		
Flovent (*fluticasone propionate*) 44 mcg		
Flovent (*fluticasone propionate*) 110 mcg		
Flovent (*fluticasone propionate*) 220 mcg		
Flovent Rotadisk (*fluticasone propionate*) 50 mcg		
Flovent Rotadisk (*fluticasone propionate*) 100 mcg		
Flovent Rotadisk (*fluticasone propionate*) 250 mcg		
Advair Diskus (*fluticasone propionate/salmeterol*) 100 mcg		
Advair Diskus (*fluticasone propionate/salmeterol*) 250 mcg		
Advair Diskus (*fluticasone propionate/salmeterol*) 500 mcg		
Azmacort (*triamcinolone acetonide*) 100 mcg		
Other (*please specify*_____)		

38.1 In the last 4 weeks, have you used any other medications for breathing problems?

1.Yes ___ 0.No ___

If yes:

38.2 What other medications have you used in the last 4 weeks? (*check all that apply*)

Drug	☑
Serevent (salmeterol)	
Combivent (albuterol/ipatropium)	
Intal (cromolyn sodium)	
Tilade (nedocromil sodium)	
Duraphyl, Slo-bid, Slo-phyllin, Theo-24, Theobid, Theo-dur, Uniphyl (theophylline)	
Choledyl (oxitriphylline)	
Aminodor, Dura-Tabs (aminophylline)	
Singulair (montelukast sodium)	
Accolate (zafirlukast)	
Zyflo (zileuton)	
Foradil (formoterol fumarate)	
Xolair (Omalizumab)	
Xopenex (levalbuterol HCL)	
Other (please specify_____)	

39.1 In the last 12 months, have you used steroid or corticosteroid pills such as Prednisone, Medrol, or Decadron for your breathing problems?

1.Yes ___ 0.No ___

If yes:

39.2 Have you used steroid or coticosteroid pills every day or every other day for the **entire** last 12 months? 1.Yes ___ 0.No ___

If no to 39.2:

39.3 In the last 12 months, have you used a short course, or "burst," of oral steroids or corticosteroids?

1.Yes ___ 0.No ___

If yes to 39.3:

39.4 In the last 12 months, how many times did you use a short course or "burst" of oral steroids or corticorsteroids? _____Times

40.1 Have you *ever* had allergy shots (immunotherapy)? 1.Yes ___ 0.No ___

If yes:

40.2 How old were you when the allergy shots were started? _____ Years Old

41.1 In the last 4 weeks have you used any prescription or over-the-counter medications for nasal-sinus or eye problems? 1.Yes ___ 0.No ___

If Yes:

- Antihistamine pills (Claritin, Zyrtec, Allegra etc)
- Decongestant pills (Sudafed, Actifed, etc)
- Decongestant nasal spray (Afrin, Otrivin, etc)
- Prescription nasal spray (Flonase, Nasalcrome, Atrovent nasal spray,etc)
- Eye drops (Visine, Clear eyes, Livostin, etc)
- Other (please specify _____)

42. Have you *ever* been told by a physician that you had any of the following conditions?

IF YES: What month and year were you first diagnosed?

Conditions	Told by MD you had it?	Month and Year of first diagnosis?
42.1 Hay fever or nasal allergies	1.Yes ___ 0.No ___	
42.2 Sinusitis or sinus infections	1.Yes ___ 0.No ___	
42.3 Eczema, dermatitis, or skin allergy	1.Yes ___ 0.No ___	
42.4 Acute bronchitis	1.Yes ___ 0.No ___	
42.5 Chronic bronchitis	1.Yes ___ 0.No ___	
42.6 Emphysema	1.Yes ___ 0.No ___	
42.7 Pneumonia	1.Yes ___ 0.No ___	
42.8 Hypersensitivity Pneumonitis	1.Yes ___ 0.No ___	
42.9 Sarcoidosis	1.Yes ___ 0.No ___	
42.10 Heart disease	1.Yes ___ 0.No ___	

43. Has any of your immediate biological family (parents, brothers or sisters, or children) ever had the

following:

43.1 Nasal allergies or hay fever? 1.Yes ___ 0.No ___

43.2 Eczema? 1.Yes ___ 0.No ___

43.3 Asthma? 1.Yes ___ 0.No ___

The next set of questions asks for your views about your health.

44.1 In general, would you say your health is:

___Excellent ___Very good ___Good ___Fair ___Poor

45. The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

45.1 <u>Moderate activities</u>, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.

___Yes, Limited a Lot ___Yes, Limited a Little ___No, Not Limited at All

45.2 Climbing <u>several</u> flights of stairs.

___Yes, Limited a Lot ___Yes, Limited a Little ___No, Not Limited at All

46. During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?

46.1 <u>Accomplished less</u> than you would like…

___All of the time ___Most of the time ___Some of the time ___A little of the time ___None of the time

46.2 Were limited in the <u>kind</u> of work or other activities…

___All of the time ___Most of the time ___Some of the time ___A little of the time ___None of the time

47. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?

47.1 <u>Accomplished less</u> than you would like…

___All of the time ___Most of the time ___Some of the time ___A little of the time ___None of the time

47.2 Did work or other activities <u>less carefully than usual</u>…

___All of the time ___Most of the time ___Some of the time ___A little of the time ___None of the time

48.1 During the past 4 weeks, how much did <u>pain</u> interfere with your normal work (including both work outside

the home and housework)?

___Extremely ___Quite a bit ___Moderately ___A little bit ___Not at all

49.1 These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much time during the past 4 weeks….

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Have you felt calm and peaceful?	___	___	___	___	___
Did you have a lot of energy?	___	___	___	___	___
Have you felt downhearted and depressed?	___	___	___	___	___

50.1 During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

___All of the time ___Most of the time ___Some of the time ___A little of the time ___None of the time

Home Environment

We are now going to ask you a few questions about your home.

51.1 Is gas used for cooking? 1.Yes ___ 0.No ___

52.1 Is an exhaust fan that vents to the outside used regularly when cooking in your kitchen? 1.Yes ___ 0.No ___

53.1 Are unvented gas logs, an unvented gas fireplace, or an unvented gas stove used in your home? 1.Yes ___ 0.No ___

54.1 Is a wood burning stove or fireplace used in your home? 1.Yes ___ 0.No ___

55.1 In the ***last 12 months***, have you used a humidifier or vaporizer in your home? (Include any humidifier built into the heating system) 1.Yes ___ 0.No ___

56.1 During the last 12 months, has a dehumidifier been regularly used to reduce moisture inside your home? 1.Yes ___ 0.No ___

57.1 Do you use an outside exhaust fan in your bathroom? 1.Yes ___ 0.No ___

58.1 During the ***last 12 months***, has there been mold or mildew on any surfaces (other than food) inside your home? 1.Yes ___ 0.No ___

59.1 During the ***last 12 months***, have you smelled moldy or musty odors inside your home?
1.Yes ___ 0.No ___

60.1 During the ***last 12 months***, has there been water damage to your home or its contents, for example from broken pipes, leaks, or floods? 1.Yes ___ 0.No ___

61.1 Do you have carpeting or rugs in your bedroom? 1.Yes ___ 0.No ___

62.1 Do you have a dog, cat, other furry pets, or a bird in your home?
MARK ALL THAT APPLY
___ NONE
___ Dogs
___ Cats
___ Pet mice, rats, hamsters, gerbils
___ Other furry pets: _____
___ Birds

63.1 In the ***last 12 months*** have you seen cockroaches? 1.Yes ___ 0.No ___

64.1 In the ***last 12 months***, have any of your hobbies or projects involved exposure to dust, smoke, gas, or chemical fumes (for example, wood dust, glue, or paint)? 1.Yes ___ 0.No ___

65.1 Does anyone, not including yourself, smoke inside your home on a regular basis?
1.Yes ___ 0.No ___

66.1 Have you ever smoked cigarettes regularly? 1.Yes ___ 0.No ___
IF YES:

66.2 Do you still smoke cigarettes? 1.Yes ___ 0.No ___

Work Information

67.1 What was the date you started working at the school? __ __ / __ __ __ __
Month Year

68.1 Please indicate your current job title:

1._____Teacher
2._____Teacher's Aide
3._____Office Staff
4._____Administration
5._____Maintenance
6._____Custodian
7._____School Nurse
8._____Cafeteria/Kitchen Worker
9._____Librarian
10.____Other (*specify*_____)

69.1 Please list the room numbers (or, if no room number, room names) where you have spent most of your time in the last 4 weeks while at the school *(please list in order starting with where you spent most of your time)*:

_____
_____
_____
_____
_____

70.1 Have you had symptoms that you think may be related to the school? 1.Yes ___ 0.No ___

IF YES:

70.2 Are there any particular rooms or areas in the school where you feel you have building-related symptoms? 1.Yes ___ 0.No ___

If yes:

70.3 Please list the rooms or areas:

_____
_____
_____

Characteristics of your job

71. How satisfied are you with the following aspects of your work station?

71.1 Conversational privacy	71.2 Freedom from distracting noise
__ Very satisfied (1) __ Somewhat satisfied (2) __ Not too satisfied (3) __ Not at all satisfied (4)	__ Very satisfied (1) __ Somewhat satisfied (2) __ Not too satisfied (3) __ Not at all satisfied (4)

71.3 All in all, how satisfied are you with your job?	
__ Very satisfied (1) __ Somewhat satisfied (2) __ Not too satisfied (3) __ Not at all satisfied (4)	

72. The next series of questions asks HOW OFTEN certain things happen at your job. (Check the appropriate

box for each question.)

	Rarely (1)	Occasionally (2)	Sometimes (3)	Fairly often (4)	Very often (5)
72.1 How often does your job require you to work very fast?					
72.2 How often does your job require you to work very hard?					
72.3 How often does your job leave you with little time to get things done?					
72.4 How often is there a great deal to be done?					
72.5 How often are you clear on what your job responsibilities are?					
72.6 How often can you predict what others will expect of you on the job?					
72.7 How much of the time are your work objectives well defined?					
72.8 How often are you clear on others expect of you on the job?	what				

73. In order to better understand your responsibilities outside your normal working day, the next series of questions deals with other significant aspects of your life.

RESPONSIBILITY	Yes (1)	No (0)
73.1 Major responsibility for child care duties		
73.2 Major responsibility for housekeeping duties		
73.3 Major responsibility for care of an elderly or disabled person on a regular basis		
73.4 Regular commitment of 5 hours or more per week, paid or unpaid, outside of this job (include educational courses, volunteer work, second job, etc.)		

FORMER WORKER QUESTIONNAIRE

(To be filled in by interviewer prior to phone call)

1. Name:_____ _____

(Last Name) (First Name) ____ (MI)

2. Home Telephone Number: (__ __ __) __ __ __- __ __ __ __

3. Since we spoke to you in DATE, have you had any of following while you were working in the school:

Symptom	**Yes**	**No**	***While away from work was this symptom…***		
			Same	**Worse**	**Better**
3.1) Wheezing or whistling in your chest?					
3.2) Chest tightness?					
3.3) Shortness of breath?					
3.4) Cough?					
3.5) Awakened by an attack of breathing difficulty?					
3.6) Shortness of breath when hurrying on level ground or walking up a slight hill?					
3.7) Cough with phlegm?					
3.8) Episodes of fever and chills?					
3.9) Episodes of flu-like achiness or achy joints?					
3.10) Unusual tiredness, fatigue, or drowsiness?					
3.11) Difficulty remembering things or concentrating?					
3.12) Headaches?					
3.13) Stuffy, itchy, or runny nose?					
3.14) Sneezing?					
3.15) Dry or itchy skin?					
3.16) Episodes of watery, itchy eyes?					
3.17) Sore or dry throat?					
3.18) Sinusitis or sinus problems?					

If YES to any of 3.1 through 3.18, answer question 4. Else go to question 5.

4. Since you have stopped working at the school, are these symptoms the:

1.Same ___ 2.Worse ___ 3.Better ___

5.1 Has a physician ever told you that you have asthma? 1.Yes ___ 0.No ___

IF YES:

5.2 Date of diagnosis: ___ ___ / ___ ___ ___ ___
(Month) (Year)

5.3 Do you still have asthma? 1.Yes ___ 0.No ___

6. Date you **started** working at the school: ___ ___ / ___ ___ ___ ___
(Month) (Year)

7. Date you **stopped** working at the school:

___ ___ / ___ ___ ___ ___
(Month) (Year)

8. What was the reason you left your job at the school?

_____ 1. Transferred to another school
_____ 2. Laid-off or dismissed
_____ 3. Quit due to medical reasons
_____ 4. Quit for other than medical reasons
_____ 5. Retired
_____ 6. Other (please specify_____)
_____ 7. Refused

9.1 Have you ever smoked cigarettes regularly? 1.Yes ___ 0.No ___

IF YES:

9.2 Do you still smoke cigarettes? 1.Yes ___ 0.No ___

10. Date of Birth: __ __ / __ __ / __ __ __ __
(Mo.) (Day) (Year)

11. Gender: 1.____ Male
2.____ Female

12. Ethnicity (Please choose one):
1.____ Hispanic or Latino
0.____ Not Hispanic or Latino

13. Race (Please choose all that apply):
1.____ American Indian or Alaska Native

2.____ Asian
3.____ Black or African American
4.____ Native Hawaiian or Other Pacific Islander
5.____ White

3. Questionnaire Administered by School Nurse (NO DATA COLLECTION REQUIRED)

HEALTH QUESTIONNAIRE

1. Survey Date: __ __/__ __/2008

2. Name: _____ _____ _____
First MI Last

3. Have you had wheezing or whistling in your chest one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

4. Have you had chest tightness one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

5. Have you had shortness of breath one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

6. Have you had a cough one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

7. Have you had watery or itchy eyes one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

8. Have you had a stuffy, itchy or runny nose one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

9. Have you had a sore or dry throat one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

10. Have you had a headache one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

11. Have you had difficulty remembering things or concentrating one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

12. Have you had unusual tiredness, fatigue, or drowsiness one or more times per week in the last 4 weeks? 1.Yes ___ 0.No ___

13. Have you had sinusitis or sinus problems in the last 4 weeks? 1.Yes ___ 0.No ___

14.1 Has a physician ever told you that you have asthma? 1. Yes ___ 0.No ___

IF YES:
14.2 Do you still have asthma? 1. Yes ___ 0.No ___

15. Please indicate your current job title:

1._____Teacher
2._____Teacher's Aide
3._____Office Staff
4._____Administration
5._____Maintenance
6._____Custodian
7._____School Nurse
8._____Cafeteria/Kitchen Worker
9._____Librarian
10.____Other (*specify*_____)

16. Please list the room numbers (or, if no room number, room names) where you have spent most of your time in the last 4 weeks while at the school *(please list in order starting with where you spent most of your time)*:

_____

_____
_____
_____
_____

THANK YOU FOR YOUR TIME!