Appendix E

TAR Adult and Child Follow-Up Surveys

OMB #0923-0039
Expires:

OMB #0923-0039
Expires:

For Office Use Only
Interviewer: _________________
Date: _______________
Start: _______________
Stop: _________________

ADULT FOLLOW-UP

DEMOGRAPHICS/RESIDENTIAL HISTORY

1. **Please tell me your full name : (a) First ________ (b) Middle _________ (c) Last ______**
2. **Please tell me your date-of-birth: (a) ________ Month (b) ________ Day (c) _______Year**
3. **What is your Social Security number?_________**
4. **Sex __________________**
5. **Has your mailing address changed since last time you were interviewed? Yes No**
   IF YES, Please tell me you new mailing address.
   Address:____

OCCUPATIONAL HISTORY

6. **Since the last time we talked to you, have you had jobs, in which you worked:**
   - a. **…as a pipe or steam fitter?**
   - b. **…as a plumber?**
   - c. **…as a brake repair person?**
   - d. **…as an insulator**
   - e. **…as a dry wall finisher**
   - f. **…as a carpenter?**
   - g. **…as a roofer**
   - h. **…as an electrician**
   - i. **…as a welder**
   - j. **…in a job where you mixed, cut or sprayed asbestos material?**
   - k. **…in a shipyard, or performed ship construction or repair?**
   - l. **…in any job where you may have been exposed to asbestos?**
   - m. **…around anyone performing one of the jobs above?**

   Yes No

IF NO TO ANY OF THE ABOVE, SKIP TO QUESTION 7.
IF YES TO ANY OF THE ABOVE, PLEASE LIST EACH JOB BELOW:

Please tell me the job titles. Start with the first job you held and end with the last job you held.

Job Title

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What were your main activities or duties in this job?

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What year did you start?
What year did you end?

TOBACCO USE

Cigarettes

7. **Have you ever smoked cigarettes? This means at least 400 cigarettes or 20 packs during your whole life.**
   Yes No

   IF *NO*, PLEASE SKIP TO QUESTION 13.

8.	Do you now smoke cigarettes (as of one month ago)?	Yes No
9.	How old were you when you first started smoking regularly?	Age in years
10.	If you have stopped smoking completely, how old were you when you stopped?	Age in years
11.	How many cigarettes do you now smoke per day?	Cigarettes/day
12.	On the average over the entire time you smoked, how many cigarettes did you smoke per day? Cigarettes/day	

Pipe

13. **Have you ever smoked a pipe regularly? (*Yes* means more than 12 oz of tobacco in a lifetime.)** **Yes No**

    IF *NO*, PLEASE SKIP TO QUESTION 19.

14.	How old were you when you started to smoke a pipe regularly?	Age in years
15.	If you have stopped smoking a pipe completely, how old were you when you stopped?	Age in years
16.	On the average over the entire time you smoked a pipe, how much tobacco did you smoke per week?	oz/week
17.	How much pipe tobacco are you smoking now?	oz/week
18.	Do you or did you inhale pipe smoke?	Yes No

Cigars

19. **Have you ever smoked cigars regularly?** **Yes No**
    (Yes means more than 1 cigar for a week for a year in a lifetime.)

    IF NO, PLEASE SKIP TO QUESTION 25.

20.	How old were you when you started to smoke cigars regularly?	Age in years
21.	If you have stopped smoking cigars completely, how old were you when you stopped?	Age in years
22.	On the average over the entire time you smoked cigars, how many cigars did you smoke per week?	Cigars/week
23.	How many cigars are you smoking per week now?	Cigars/week
24.	Do you or did you inhale cigar smoke?	Not at all/Slightly/Moderately/Deeply

Smokeless tobacco

25. **Have you ever used or tried any smokeless tobacco products such as chewing tobacco or snuff?** **Yes No**

IF NO, PLEASE SKIP TO QUESTION 28.

26. While using smokeless tobacco, how many cans or pouches of tobacco do or did you use per week?

    Containers/week

27. Do you currently use smokeless tobacco products every day, some days, or not at all?

    Every day/Some days/Not at all

28. **Did any member of your family or household regularly smoke cigarettes inside the residence during the time that you lived together? Check yes for each person listed below. IF YES, please indicate how many years you lived in the same household with them while they were smoking inside the residence.**
    a. Mother ☐Yes ☐No Years
    b. Father ☐Yes ☐No Years
    c. Spouse ☐Yes ☐No Years
    d. Other ☐Yes ☐No Years
    e. Other ☐Yes ☐No Years
    f. Other ☐Yes ☐No Years
    g. Are you currently living with someone who smokes inside the residence? ☐Yes ☐No

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Medical/Symptom History

29. **Do you have a regular doctor or clinic that you go to? If YES, what is the name and address of the doctor or clinic?**
    a. Name
    b. Address

Asbestos-Related Disease

30. **Since last time you were interviewed, has your doctor told you that you had or treated you for asbestosis?**

    IF YES,
    a. When were you were first treated for asbestosis?
    b. Are you currently receiving treatment for asbestosis?
    c. Were you hospitalized for asbestosis?

31. **Since last time you were interviewed, has your doctor told you that you had or treated you for lung cancer?**

    IF YES,
    a. When were you were first treated for lung cancer?
    b. Are you currently receiving treatment for lung cancer?
    c. Were you hospitalized for lung cancer?

32. **Since last time you were interviewed, has your doctor told you that you had or treated you for mesothelioma?**

    IF YES,
    a. When were you were first treated for mesothelioma?
    b. Are you currently receiving treatment for mesothelioma?
    c. Were you hospitalized for mesothelioma?

Cough

33. **Do you usually have a cough?** **☐Yes ☐No**
(Count a cough with first smoke or on fist going out-of-doors. Exclude clearing of the throat.)
IF *NO*, SKIP TO 35.

34. **Do you usually cough as much as 4 to 6 times a day, 4 or more days out of the week?**
☐Yes ☐No

35. **Do you usually cough at all on getting up, or first thing in the morning?**
☐Yes ☐No

36. **Do you usually cough at all during the rest of the day or night?**
☐Yes ☐No

IF YES TO ANY OF THE ABOVE, ANSWER THE FOLLOWING:
37. Do you usually cough like this on most days for 3 consecutive months or more during the year?
☐Yes ☐No

38. For how many years have you had this cough? Years

Phlegm
39. **Have you ever coughed up phlegm (thick mucous) that was bloody?**
☐Yes ☐No
IF YES, ask:
c. In the past year, have you coughed up phlegm that was bloody? **☐Yes ☐No**

40. **Do you usually bring up phlegm from your chest?** **☐Yes ☐No**
(Count phlegm with the first smoke or on first going out-of-doors. Exclude phlegm from the nose. Count swallowed phlegm.)
[IF NO, SKIP TO 42].

41. **Do you usually bring up phlegm like this as much as twice a day, 4 or more days out of the week?**
☐Yes ☐No

42. **Do you usually bring up phlegm at all on getting up, or first thing in the morning?**
☐Yes ☐No

43. **Do you usually bring up phlegm at all during the rest of the day or at night?**
☐Yes ☐No

IF YES TO ANY OF 40-43, ANSWER THE FOLLOWING:
44. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?
☐Yes ☐No
45. For how many years have you had trouble with phlegm? Years

Episodes of cough and phlegm
46. **Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year?**
***(For persons who usually have cough and/or phlegm.)**

IF YES:
47. For how long have you had at least 1 such episode per year? Years

Other Medical/Symptom History

48. **Have you ever had tuberculosis?** **☐Yes ☐No**

49. **Have you ever been hospitalized for pneumonia or pleurisy?** **☐Yes ☐No**

50. **Have you ever had congestive heart failure or fluid on the lungs?** **☐Yes ☐No**

51. **Have you ever had any other chest illness?** **☐Yes ☐No**

52. **Have you ever had a significant chest injury?** **☐Yes ☐No**

53. **Have you ever had chest surgery (open heart or chest drainage tube)?** **☐Yes ☐No**

54. **Do you suffer from rheumatoid arthritis, scleroderma, or lupus?** **☐Yes ☐No**

55. **Have you ever had or do you now have any type of cancer?** **☐Yes ☐No**
    a. IF YES, Please specify the type of cancer:_____
    b. IF YES, Please specify the year of diagnosis:_______

56. **Have you ever had chest x-ray?** **☐Yes ☐No**
    a. IF YES, What year did you have your most current chest x-ray? Year
    b. IF YES, Where was this x-ray taken? Clinic and city:

57. **Have you ever been told by a doctor that you have a lung disease or condition?** **☐Yes ☐No**
    a. IF YES, What kind(s) of lung condition(s)?
    b. IF YES, When were you told about it?
    c. IF YES, Who told you about the problem? Dr.____

58. **Have you become hoarse or developed difficulty swallowing in the last year?** **☐Yes ☐No**

59. **In the past year, have you had periods of chest pain related to breathing?** **☐Yes ☐No**

60. **Have you lost more than 15 pounds without dieting over the past 6 months?** **☐Yes ☐No**

61. **Are you now troubled by shortness of breath when walking up a slight hill or when hurrying on level ground?** **☐Yes ☐No**
    a. Do you have to walk slower than people your own age because of shortness of breath? ☐Yes ☐No
    b. Do you have to stop for breath when walking at your own pace on level ground? ☐Yes ☐No
    c. Do you have to stop for breath when walking about 100 yards (or after walking several minutes) on level ground? ☐Yes ☐No
    d. Are you too short of breath to leave the house, or are you short of breath while dressing or undressing? ☐Yes ☐No

OTHER INFORMATION

62. **How concerned or worried are you that there is something in your neighborhood environment that may be harming your health?** **Not at all/A little/Very**

63. **We may ask to interview you again in the future to check up on your health status. Keeping in mind that people move, we would like to get a little more information to help us locate you in the future. Could we have the addresses of two people who live outside of your household and who would always know how to find you?**

    Yes **No**

    IF YES:

    a. Contact #1: Name/Phone Number/Address/Relationship
    b. Contact #2: Name/Phone Number/Address/Relationship

64. **Are there any comments you would like to add or any important information that you think we should know? ____________________**

65. **Interviewer comments:________________**

Thank you for participating.

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Date: _______________
Start: _______________
Stop: _________________

CHILD FOLLOW-UP

DEMOGRAPHICS/RESIDENTIAL HISTORY

1. **Please tell me your full name: (a) First _______ (b) Middle _________ (c) Last ______**

2. **What is your relationship to the child: ____________**

3. **Please tell me your child's full name: (a) First _______ (b) Middle _________ (c) Last ______**

4. **Please tell me [CHILD NAME] date-of-birth: (a) _____ Month (b) ______ Day (c) _____Year**

5. **What is [CHILD NAME] Social Security number?_________**

6. **What is [CHILD NAME] Sex? __________________**

7. **Has [CHILD NAME] mailing address changed since last time an interview was conducted on his/her behalf?** **Yes** **No**
   IF YES, Please tell me [CHILD NAME] new mailing address.
   Address: ____

TOBACCO USE

8. **Has [CHILD NAME] ever smoked cigarettes? This means at least 400 cigarettes or 20 packs during his/her whole life.**
   Yes **No**
   IF *NO*, PLEASE SKIP TO QUESTION 14.

9. Does [CHILD NAME] now smoke cigarettes (as of one month ago)? Yes No
10. How old was[CHILD NAME] when he/she first started smoking regularly?
    Age in years
11. If [CHILD NAME] has stopped smoking completely, how old was he/she when he/she stopped?
    Age in years
12. How many cigarettes does [CHILD NAME] now smoke per day? Cigarettes/day

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13. On the average over the entire time [CHILD NAME] smoked, how many cigarettes did he/she smoke per day?	Cigarettes/day

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14. **Has [CHILD NAME] ever smoked a pipe regularly? (*Yes* means more than 12 oz of tobacco in a lifetime.)** **Yes** **No**

IF *NO*, PLEASE SKIP TO QUESTION 20:

15. How old was [CHILD NAME] when he/she started to smoke a pipe regularly? Age in years
16. If [CHILD NAME] has stopped smoking a pipe completely, how old was he/she when he/she stopped? Age in years
17. On the average over the entire time [CHILD NAME] smoked a pipe, how much tobacco did he/she smoke per week? oz/week
18. How much pipe tobacco is [CHILD NAME] smoking now? oz/week
19. Does or did [CHILD NAME] inhale pipe smoke? Yes No

20. **Has [CHILD NAME] ever smoked cigars regularly?** **Yes** **No**
(Yes means more than 1 cigar for a week for a year in a lifetime.)

IF NO, PLEASE SKIP TO QUESTION 26:

21. How old was [CHILD NAME] when he/she started to smoke cigars regularly? Age in years
22. If [CHILD NAME] has stopped smoking cigars completely, how old was he/she when he/she stopped? Age in years
23. On the average over the entire time [CHILD NAME] smoked cigars, how many cigars did he/she smoke per week? Cigars/week
24. How many cigars is [CHILD NAME] smoking per week now? Cigars/week
25. Does or did [CHILD NAME] inhale cigar smoke? Not at all/Slightly/Moderately/Deeply

26. **Has [CHILD NAME] ever used or tried any smokeless tobacco products such as chewing tobacco or snuff?** **Yes**
No IF NO, PLEASE SKIP TO QUESTION 29:

27. While using smokeless tobacco, how many cans or pouches of tobacco does or did [CHILD NAME] use per week? Containers/week
28. Does [CHILD NAME] currently use smokeless tobacco products every day, some days, or not at all? Every day/Some days/Not at all

29. **Did any member of [CHILD NAME] family or household regularly smoke cigarettes inside the residence during the time that they lived together? Check yes for each person listed below.**
IF YES, please indicate how many years you lived in the same household with them while they were smoking inside the residence.
    a. Mother Yes No Years
    b. Father Yes No Years
    c. Spouse Yes No Years
    d. Other Yes No Years
    e. Other Yes No Years
    f. Other Yes No Years
    g. Are you currently living with someone who smokes inside the residence?
    h. Yes No

Medical/Symptom History

30. **Does [CHILD NAME] have a regular doctor or clinic that he/she goes to? If YES, what is the name and address of the doctor or clinic?**
    a. Name
    b. Address

Asbestos-Related Disease

31. **Since last time you were interviewed, has his/her doctor told you that [CHILD NAME] had or treated him/her for asbestosis?**
    IF YES,
    a. When was [CHILD NAME] first treated for asbestosis?
    b. Is [CHILD NAME] currently receiving treatment for asbestosis?
    c. Was [CHILD NAME] hospitalized for asbestosis?

32. **Since last time you were interviewed, has his/her doctor told you that [CHILD NAME] had or treated him/her for lung cancer?**
    IF YES,
    a. When was [CHILD NAME] first treated for lung cancer?
    b. Is [CHILD NAME] currently receiving treatment for lung cancer?
    c. Was [CHILD NAME] hospitalized for lung cancer?

33. **Since last time you were interviewed, has his/her doctor told you that [CHILD NAME] had or treated him/her for mesothelioma?**
    IF YES,
    a. When was [CHILD NAME] first treated for mesothelioma?
    b. Is [CHILD NAME] currently receiving treatment for mesothelioma?
    c. Was [CHILD NAME] hospitalized for mesothelioma?

Cough

34. **Does [CHILD NAME] usually have a cough?** **Yes** **No**

(Count a cough with first smoke or on fist going out-of-doors. Exclude clearing of the throat.) IF *NO*, SKIP TO 36.

35. **Does [CHILD NAME] usually cough as much as 4 to 6 times a day, 4 or more days out of the week?** **Yes** **No**

36. **Does [CHILD NAME] usually cough at all on getting up, or first thing in the morning?** **Yes** **No**

37. **Does [CHILD NAME] usually cough at all during the rest of the day or night?** **Yes** **No**

IF YES TO ANY OF THE ABOVE, ANSWER THE FOLLOWING:

38. Does [CHILD NAME] usually cough like this on most days for 3 consecutive months or more during the year? Yes No
39. For how many years has he/she had this cough? Years

Phlegm

40. **Has [CHILD NAME] ever coughed up phlegm (thick mucous) that was bloody?** **Yes** **No**

IF YES, ask:

a. In the past year, has [CHILD NAME] coughed up phlegm that was bloody? Yes No

41. **Does [CHILD NAME] usually bring up phlegm from your chest?** **Yes** **No**
(Count phlegm with the first smoke or on first going out-of-doors. Exclude phlegm from the nose. Count swallowed phlegm.)
[IF NO, SKIP TO 43].

42. **Does [CHILD NAME] usually bring up phlegm like this as much as twice a day, 4 or more days out of the week?** **Yes** **No**

43. **Does [CHILD NAME] usually bring up phlegm at all on getting up, or first thing in the morning?** **Yes** **No**

44. **Does [CHILD NAME] usually bring up phlegm at all during the rest of the day or at night?** **Yes** **No**

IF YES TO ANY OF 41-44, ANSWER THE FOLLOWING:

45. Does [CHILD NAME] bring up phlegm like this on most days for 3 consecutive months or more during the year? Yes No

46. For how many years has [CHILD NAME] had trouble with phlegm? Years

Episodes of cough and phlegm

47. **Has [CHILD NAME] had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year?**
***(For persons who usually have cough and/or phlegm.)**

IF YES:

48. For how long has [CHILD NAME] had at least 1 such episode per year? Years

Other Medical/Symptom History

49. **Has [CHILD NAME] ever had tuberculosis?** **Yes** **No**

50. **Has [CHILD NAME] ever been hospitalized for pneumonia or pleurisy?** **Yes** **No**

51. **Has [CHILD NAME] ever had congestive heart failure or fluid on the lungs?** **Yes** **No**

52. **Has [CHILD NAME] ever had any other chest illness?** **Yes** **No**

53. **Has [CHILD NAME] ever had a significant chest injury?** **Yes** **No**

54. **Has [CHILD NAME] ever had chest surgery (open heart or chest drainage tube)?** **Yes** **No**

55. **Does [CHILD NAME] suffer from rheumatoid arthritis, scleroderma, or lupus?** **Yes** **No**

56. **Has [CHILD NAME] ever had or have now have any type of cancer?** **Yes** **No**

a. IF YES, Please specify the type of cancer:_____
b. IF YES, Please specify the year of diagnosis:_______

57. **Has [CHILD NAME] ever had chest x-ray?** **Yes** **No**

a. IF YES, What year did [CHILD NAME] have his/her most current chest x-ray? Year
b. IF YES, Where was this x-ray taken? Clinic and city:

58. **Have you ever been told by a doctor that [CHILD NAME] has a lung disease or condition?** **Yes** **No**

a. IF YES, What kind(s) of lung condtion(s)?
b. IF YES, When were you told about it?
c. IF YES, Who told you about the problem? Dr.____

59. **Has [CHILD NAME] become hoarse or developed difficulty swallowing in the last year?** **Yes** **No**

60. **In the past year, has [CHILD NAME] had periods of chest pain related to breathing?** **Yes** **No**

61. **Has [CHILD NAME] lost more than 15 pounds without dieting over the past 6 months?** **Yes** **No**

62. **Is [CHILD NAME] troubled by shortness of breath when walking up a slight hill or when hurrying on level ground?** **Yes** **No**

a. Does [CHILD NAME] have to walk slower than people his/her own age because of shortness of breath? Yes No

b. Does [CHILD NAME] have to stop for breath when walking at his/her own pace on level ground? Yes No

c. Does [CHILD NAME] have to stop for breath when walking about 100 yards (or after walking several minutes) on level ground? Yes No

d. Is [CHILD NAME] too short of breath to leave the house, or is he/she short of breath while dressing or undressing? Yes No

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OTHER INFORMATION

63. **How concerned or worried are you that there is something in your neighborhood environment that may be harming your child's health?**

Not at all/A little/Very

64. **We we may ask to interview your child again in the future to check up on his/her health status. Keeping in mind that people move, we would like to get a little more information to help us locate your child in the future. Could we have the addresses of two people who live outside of your child's household and who would always know how to find him/her?**

Yes **No**

IF YES:

a. Contact #1: Name/Phone Number/Address/Relationship
b. Contact #2: Name/Phone Number/Address/Relationship

65. **Are there any comments you would like to add or any important information that you think we should know?:____________________**

66. **Interviewer comments:________________**

Thank you for participating.