Biological Sample Collection Questionnaire
Agricultural Health Study

Location of Residence (County, State): _____

Date: _____/_____/_____
MM DD YYYY

OMB #: 0925-0406
Expiration date: 10/31/2011

[Display subject ID and Participant information on CAPI "face sheet"]

Screening questions to ask prior to consent:

1. Is your name ^DSP.Respondent_Fullname and is your date of birth ^STN.Respondent_Birthdate?
   Yes _____ No _____ (if no, answer the following question)

   Does another person with a similar name but a different date of birth live here?
   Yes _____ No _____ (if no, answer the following question)

   Is it possible that the numbers in the date of birth, ^STN.Respondent_Birthdate, have been transposed, misread, or are reversed?
   Yes _____ No _____ (if yes, answer the following question)

   What is your correct date of birth? _____/_____/_____
   MM DD YYYY

2. Do you have a blood clotting disorder such as hemophilia?
   Yes _____ No _____ (This question will also be asked on the screening call. If yes, the individual will be ineligible.)

3. Other than non-melanoma skin cancer, have you been diagnosed by a doctor with any type of cancer in the last three years? (This will also be asked on the screening call. If yes, the individual will be ineligible.) Yes _____ No _____

   a. If yes, list each cancer and date of diagnosis (add additional rows as needed):

1st cancer _____date of diagnosis _____/_____/_____
MM DD YYYY

2nd cancer (if applicable)_____ date of diagnosis _____/_____/_____
MM DD YYYY

4. Have you ever had a digital rectal examination of the prostate? Would you say never, once, or more than once?
No _____ Yes _____ Yes, more than once _____ Don't know _____

5. Have you ever had a blood test for prostate cancer, for example PSA? Would you say never, once, or more than once?
No _____ Yes _____ Yes, more than once _____ Don't know _____

6. Have you ever has a colonoscopy or sigmoidoscopy to examine the colon and rectum? Would you say never, once, or more than once?
No _____ Yes _____ Yes, more than once _____ Don't know _____

[Obtain consent, and proceed with questionnaire]

1. How tall are you? _____feet / inches

2. How much do you weigh now? _____ pounds

3. In the last 7 days, have you used aspirin or aspirin-containing products, such as Bayer, Bufferin, or Anacin? (Please do not include aspirin-free products such as Tylenol and Panadol.)
Yes _____ No _____ (if yes, answer the following questions)
    a. Product name: _____
    b. Product strength: Adult strength (usually 325mg) _____ Baby strength (usually 81mg) _____ Some other strength _____ Don't know the strength _____
    c. How many pills of aspirin or aspirin-containing products have you taken in the last 7 days? _____
    d. When did you last take aspirin or aspirin-containing products?
    _____/_____/_____
    MM DD YYYY

4. In the last 7 days, have you used ibuprofen-containing products, such as Advil, Nuprin, or Motrin?
Yes _____ No _____ (if yes, answer the following questions)
    a. Product name: _____
    b. How many pills of ibuprofen-containing products have you taken in the last 7 days? ____
    c. When did you last take ibuprofen-containing products? _____/_____/_____
    MM DD YYYY

5. Are you regularly taking any blood thinning medications (e.g. Heparin, Coumadin)?
   Yes _____ No _____

   a. If yes, please list the blood thinning medication(s) that you regularly take:
      _____

6. Do you regularly take any prescribed medicines? Yes _____ No _____
   a. If yes, list each prescription medication taken: _____
      _____

7. Have you ever been diagnosed with any of the following conditions?
   Heart disease: Yes _____ No _____
   Diabetes: Yes _____ No _____
   Autoimmune conditions (e.g., multiple sclerosis, sarcoidosis, lupus, or Sjogren's disease): Yes _____ No _____
   Arthritis: Yes _____ No _____
   High blood pressure or hypertension: Yes _____ No _____

8. Have you had any of the following conditions in the last 30 days?

   a. Cold or flu: Yes _____ No _____ (if yes, answer below)
      When did symptoms begin? _____
      When did symptoms resolve? _____

   b. Bronchitis or pneumonia: Yes _____ No _____ (if yes, answer below)
      When did symptoms begin? _____
      When did symptoms resolve? _____

   c. Sinusitis or sinus problems: Yes _____ No _____ (if yes, answer below)
      When did symptoms begin? _____
      When did symptoms resolve? _____

   d. Any other type of infection: Yes _____ No _____ (if yes, answer below)
      List type(s)_____
      When did symptoms begin? _____
      When did symptoms resolve? _____

9. During the last 12 months, have you had any medical or dental x-rays or any other radiologic procedures?
   Yes _____ No _____

   a. If yes, list each:

      Type of procedure: _____

      Date of procedure: _____/_____/_____
      MM DD YYYY

10. How many servings of alcoholic beverages did you drink in the last seven days? A serving of an alcoholic beverage is defined as 12 fluid ounces of beer, 5 fluid ounces of wine, and 1.5 fluid ounces of hard liquor. Number of servings: _____

11. How many servings of alcoholic beverages did you drink in the last 24 hours? A serving of an alcoholic beverage is defined as 12 fluid ounces of beer, 5 fluid ounces of wine, and 1.5 fluid ounces of hard liquor. Number of servings: _____

12. How often do you currently smoke or use the following tobacco products?

Product	Every day	Some days	Not at all
Cigarettes			
Pipe			
Cigars			
Cigarillos			
Chewing tobacco			
Snuff			
Other (specify): _____			

Other agricultural exposures section

Now we would like to ask you a few questions about your activities at work and on your farm.

13. In the last 12 months, have you personally performed farm work or farming activities?
Yes _____ No _____ (if no, skip to welding question)

14. Excluding gardens for personal use, what crops, including fruits and vegetables, were raised on your farm in the last 12 months?

None	Corn pop	Peaches	Sweet potatoes
Apples	Corn seed	Peanuts	Tomatoes
Alfalfa	Corn sweet	Peppers	Tobacco
Barley	Cotton	Potatoes	Wheat
Bermuda grass	Cucumbers	Rye	Nursery crops
Blueberries	Grapes	Snap beans	Pumpkins
Cabbage	Hay or forage	Sorghum	Other:
Christmas trees	Melons	Soybeans	_____
Corn field	Oats	Strawberries	

15. In the last 12 months, what type and number of poultry or livestock were raised on your farm?

Type	Yes/No	Number
None		
Beef cattle		
Dairy cattle		

Hog/swine		
Poultry		
Poultry for eggs		
Sheep or goats		
Horses		
Other		

16. If yes to raising poultry or poultry for eggs, have you spent time in a poultry confinement area within the last month?
Yes___ No____

17. If yes to swine, have you spent time in swine confinement area within the last month?
Yes___ No___

18. In the last month, how many times have you performed the following activities?

Grind animal feed	Not at all 1-3 times 4-20 times >20 times
Milk cows	Not at all 1-3 times 4-20 times >20 times
Clean grain bins	Not at all 1-3 times 4-20 times >20 times
Work with or around moldy hay or straw	Not at all 1-3 times 4-20 times >20 times

19. In the last 7 days, have you done any welding? Yes _____ No _____

20. In the last 7 days, have you done any painting? Yes _____ No _____

21. In the last 7 days, have you repaired engines? Yes _____ No _____

Non-farm occupation information

22. Do you currently have a job other than working on a farm?
Yes _____ No _____ (If yes, please answer the following questions)

    a. What is your current job other than farming? _____

b. What type of business is this job in? _____

c. How long have you had this job? _____ months / years

d. Is this job year round or seasonal?
Year round _____ Seasonal _____

Occupational Pesticide Use Module

We would now like to ask about your use of pesticides in the last 12 months. This includes the use of herbicides, insecticides, fungicides, fumigants, or other chemicals used to kill plants, insects, fungi, molds, or rodents. Please do not include the use of antibiotics, sanitizers, antimicrobial soaps or fertilizers.

1. In the last 12 months, have you personally mixed, loaded, handled or applied these chemicals for use on crops, animals, or any other purpose NOT including home and garden use? We will ask you separately about the use of pesticides in your home and garden.

Yes _____ No _____ (If no, then stop here. If yes, please answer the following questions in a separate module for each product used.)

2. Which products have you used in the last 12 months? Please give the product trade name, if possible:
_____

If label is available, active ingredient and EPA Registration #: _____

3. In the last 12 months, on how many days did you mix, load or apply [insert pesticide name]?

Total number of days: _____
Don't know

4. We would like to ask you about the dates of the three most recent uses of [insert pesticide name] within the last 12 months and the amount of time that you spent mixing, loading or applying [insert pesticide name] on each date.

	Date (start with most recent use)	Time spent (hours)
1		
2		
3		

5. In the last 12 months, did you personally mix or load [insert pesticide name]?

Yes _____ No _____ (If yes, answer below)

a. Was the pesticide product that you mixed/loaded a:
Liquid

Powder
Granule
Dissolvable packet
Other: specify _____

b. What type of personal protective equipment did you wear when mixing/loading [insert pesticide name]? Please select all that apply:
Gloves, specify type: chemical resistant (like nitrile)
rubber or plastic waterproof gloves
thin disposable glove (like latex)
fabric or leather
other gloves: _____

Goggles
Face shield
Disposable coveralls, like Tyvek
Chemical-resistant jacket and pants
Chemical-resistant apron
Rubber boots
Respirator, specify type: _____
Dust mask
Long-sleeved shirt
Other: specify_____
None

6. In the last 12 months, did you personally apply [insert pesticide name]?

Yes _____ No _____ (If yes, answer below)

a. Was [insert pesticide name] applied to:
Crop(s), specify: _____
Animals or animal confinement areas
Other, specify: _____

b. Was [insert pesticide name] applied as a liquid, powder, granule or something else?
Liquid
Powder
Granule
Something else: specify _____

c. What application method(s) was used?
Broadcast or boom spray
Hand spray
Air blast
Other: specify_____

d. What type of personal protective equipment did you wear when applying [insert pesticide name]? Please select all that apply:
Gloves, specify type: chemical resistant (like nitrile)
rubber or plastic waterproof gloves
thin disposable glove (like latex)

fabric or leather
other gloves: _____

Goggles
Face shield
Disposable coveralls, like Tyvek
Chemical-resistant jacket and pants
Chemical-resistant apron
Rubber boots
Respirator, specify type: _____
Dust mask
Long-sleeved shirt
Other: specify_____
None

Home and Garden Pesticide Use Questions

We would now like to ask about your use of pesticides in your home and garden in the last 12 months. This includes the use of herbicides, insecticides, fungicides, fumigants, or other chemicals used to kill plants, insects, fungi, molds, or rodents. Please do not include the use of antibiotics, sanitizers, antimicrobial soaps or fertilizers.

1. In the last 12 months, have you personally used pesticides in your home and garden?

Yes _____ No _____ (If no, then stop here. If yes, please answer the following question.)

2. Which products have you used in your home and garden in the last 12 months? Please give the product trade name, if possible: _____

If label is available, active ingredient and EPA Registration #: _____