

# Marine Corps Health Survey

## Instructions

- Please use a black or blue pen to complete this form. Do not use a felt-tip pen or a pencil.
- Mark  to indicate your answer.
- If you want to change your answer, mark an  on the wrong answer and put an X in the box next to the correct answer.
- Your answers are important. Please print clearly, using uppercase, block letters (for example, "WEDNESDAY").

1. Are you completing this survey for yourself?

- Yes → **GO TO RESIDENTIAL HISTORY ON PAGE XX**  
 No

2. Is the person to whom this survey is addressed unable to complete the survey or is he/she deceased?

- Unable  
 Deceased

If you are filling out this survey on behalf of someone else, please provide your name and other information requested below.

Your Name:

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Suffix (Jr., Sr., etc.): \_\_\_\_\_

Public reporting burden of this collection of information is estimated to average 45 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 the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: CDC/ATSDR Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333; ATTN: PRA (0923-xxxx).

3. What is your relationship to the person for whom you are completing this survey?

Survey ID# \_\_\_\_\_

Spouse



Were you married to the participant while he/she was living or working at Camp Lejeune or Camp Pendleton?

Yes

No

Sibling

Parent

Child

Cousin

Other-specify: \_\_\_\_\_

IMPORTANT: Please answer all questions in this survey as they relate to the participant. In each question, the word "you" will refer to the participant, not yourself.

### Residential History

4. Were you active duty at Camp Lejeune or Camp Pendleton?

Yes

No → **GO TO QUESTION 10**

Please use the table below to tell us about the time you lived at Camp Lejeune or Camp Pendleton. **After completing the table, go to Medical History section on page XX.**

5. Where were you stationed? (Please mark one.)	6. What unit were you assigned to?	7. Where on base did you reside? (location of barracks/family housing area)	8. When did you start living there? (month and year)	9. When did you stop living there? (month and year)
<input type="checkbox"/> Lejeune <input type="checkbox"/> Pendleton	_____	_____ _____	<input type="text"/> /_____ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> /_____ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Lejeune <input type="checkbox"/> Pendleton	_____	_____ _____	<input type="text"/> /_____ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> /_____ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Lejeune <input type="checkbox"/> Pendleton	_____	_____ _____	<input type="text"/> /_____ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> /_____ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Lejeune <input type="checkbox"/> Pendleton	_____	_____ _____	<input type="text"/> /_____ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> /_____ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Lejeune <input type="checkbox"/> Pendleton	_____	_____ _____	<input type="text"/> /_____ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> /_____ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

GO TO MEDICAL HISTORY SECTION ON PAGE XX

10. Were you living with someone while they were active duty at Camp Lejeune or Camp Pendleton?

- Yes → Please give us the full name of the active duty member.
- No → **GO TO MEDICAL HISTORY SECTION ON PAGE XX**

Use the table below to tell us about the time you lived at Camp Lejeune or Camp Pendleton.

11. Where were you living? (Please mark one)	12. What was the address? (street number, street name or housing area)	13a. Start Month	13b. Start Year	14a. End Month	14b. End Year
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Survey ID# \_\_\_\_\_

<b>one.)</b>					
<input type="checkbox"/> Lejeune <input type="checkbox"/> Pendleton	_____ _____	<input type="checkbox"/> m <input type="checkbox"/> m	<input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y	<input type="checkbox"/> m <input type="checkbox"/> m	<input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y
<input type="checkbox"/> Lejeune <input type="checkbox"/> Pendleton	_____ _____	<input type="checkbox"/> m <input type="checkbox"/> m	<input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y	<input type="checkbox"/> m <input type="checkbox"/> m	<input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y
<input type="checkbox"/> Lejeune <input type="checkbox"/> Pendleton	_____ _____	<input type="checkbox"/> m <input type="checkbox"/> m	<input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y	<input type="checkbox"/> m <input type="checkbox"/> m	<input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y
<input type="checkbox"/> Lejeune <input type="checkbox"/> Pendleton	_____ _____	<input type="checkbox"/> m <input type="checkbox"/> m	<input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y	<input type="checkbox"/> m <input type="checkbox"/> m	<input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y <input type="checkbox"/> y

**Medical History**

We are interested in finding out about any diseases, medical conditions, and illnesses you may have had since you first were stationed, employed, or living at Camp Lejeune or Camp Pendleton.

15. What is the name, address, and phone number of your current primary care doctor or health care provider?

Doctor Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

16. Between the time you were first stationed, employed, or living at Camp Lejeune or Camp Pendleton and now, have you been told by a doctor or other health care provider that you had cancer or a malignancy of any kind?

- Yes
- No → **GO TO QUESTION 30 ON PAGE**

17. Thinking of the first diagnosed cancer, what kind of cancer was it? (Mark only one answer.):

<input type="checkbox"/> Appendix	<input type="checkbox"/> Liver	<input type="checkbox"/> Skin (don't know what kind)
<input type="checkbox"/> Bladder	<input type="checkbox"/> Lung	<input type="checkbox"/> Small intestine
<input type="checkbox"/> Bone	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Soft tissue (muscle or fat)
<input type="checkbox"/> Brain	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Stomach

Survey ID# \_\_\_\_\_

<input type="checkbox"/> Breast	<input type="checkbox"/> Mouth/Tongue/Lip	<input type="checkbox"/> Testicle
<input type="checkbox"/> Cervix	<input type="checkbox"/> Multiple Myeloma	<input type="checkbox"/> Throat or Pharynx
<input type="checkbox"/> Colon	<input type="checkbox"/> Ovary	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Esophagus	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Uterus
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Prostate	<input type="checkbox"/> Other-specify: _____
<input type="checkbox"/> Kidney	<input type="checkbox"/> Rectum	
<input type="checkbox"/> Larynx or Windpipe	<input type="checkbox"/> Skin (non-melanoma)	<input type="checkbox"/> Don't know
<input type="checkbox"/> Leukemia		

18. How old were you when this cancer was first diagnosed?  years old

19. Was this:

- A primary cancer, or
- A cancer that had spread or metastasized from somewhere else in the body?

20. What state were you living in when this cancer was first diagnosed? \_\_\_\_\_

21. What was the name of the doctor or other health care provider who first diagnosed this cancer? Please provide their name, address, and phone number.

Doctor Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

22. Were you ever hospitalized for treatment of this cancer? If yes, please specify where you were first hospitalized for this cancer.

- Yes → Name of Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
- No

23. Between the time you were first stationed, employed, or living at Camp Lejeune or Camp Pendleton and now, were you diagnosed with a second kind of cancer? If yes, what kind of cancer was it? (Mark only one answer.)

- Yes
- No → **GO TO QUESTION 30 ON PAGE**

Survey ID# \_\_\_\_\_

<input type="checkbox"/> Appendix	<input type="checkbox"/> Liver	<input type="checkbox"/> Skin (don't know what kind)
<input type="checkbox"/> Bladder	<input type="checkbox"/> Lung	<input type="checkbox"/> Small intestine
<input type="checkbox"/> Bone	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Soft tissue (muscle or fat)
<input type="checkbox"/> Brain	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Stomach
<input type="checkbox"/> Breast	<input type="checkbox"/> Mouth/Tongue/Lip	<input type="checkbox"/> Testicle
<input type="checkbox"/> Cervix	<input type="checkbox"/> Multiple Myeloma	<input type="checkbox"/> Throat or Pharynx
<input type="checkbox"/> Colon	<input type="checkbox"/> Ovary	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Esophagus	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Uterus
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Prostate	<input type="checkbox"/> Other-specify: _____
<input type="checkbox"/> Kidney	<input type="checkbox"/> Rectum	
<input type="checkbox"/> Larynx or Windpipe	<input type="checkbox"/> Skin (non-melanoma)	<input type="checkbox"/> Don't know
<input type="checkbox"/> Leukemia		

24. How old were you when this cancer was first diagnosed?  years old

25. Was this:

- A primary cancer, or
- A cancer that had spread or metastasized from somewhere else in the body?

26. What state were you living in when this second cancer was first diagnosed? \_\_\_\_\_

27. What was the name of the doctor or other health care provider who first diagnosed this cancer? Please provide their name, address, and phone number.

Doctor Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

28. Were you ever hospitalized for treatment of this cancer? If yes, please specify where you were first hospitalized for this cancer.

Yes → Name of Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

No

Survey ID# \_\_\_\_\_

29. Between the time you were first stationed, employed, or living at Camp Lejeune or Camp Pendleton and now, have you been diagnosed with any other kind of cancer? If yes, please mark all that apply.

- Yes  
 No → GO TO NEXT PAGE

<input type="checkbox"/> Appendix	<input type="checkbox"/> Liver	<input type="checkbox"/> Skin (don't know what kind)
<input type="checkbox"/> Bladder	<input type="checkbox"/> Lung	<input type="checkbox"/> Small intestine
<input type="checkbox"/> Bone	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Soft tissue (muscle or fat)
<input type="checkbox"/> Brain	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Stomach
<input type="checkbox"/> Breast	<input type="checkbox"/> Mouth/Tongue/Lip	<input type="checkbox"/> Testicle
<input type="checkbox"/> Cervix	<input type="checkbox"/> Multiple Myeloma	<input type="checkbox"/> Throat or Pharynx
<input type="checkbox"/> Colon	<input type="checkbox"/> Ovary	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Esophagus	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Uterus
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Prostate	<input type="checkbox"/> Other-specify: _____
<input type="checkbox"/> Kidney	<input type="checkbox"/> Rectum	
<input type="checkbox"/> Larynx or Windpipe	<input type="checkbox"/> Skin (non-melanoma)	<input type="checkbox"/> Don't know
<input type="checkbox"/> Leukemia		

Between the time you were first were stationed, employed, or living at Camp Lejeune or Camp Pendleton and now, were you told by a doctor or other health care provider that you had any of the following conditions?

	a. What was the name of the disease?	b. How old were you when you were first told this?
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Survey ID# \_\_\_\_\_

<p>30. Kidney disease or kidney failure? Do not include kidney cancer, kidney stones, bladder infection or incontinence.</p> <p><input type="checkbox"/> Yes →  <input type="checkbox"/> No (GO TO Q31)</p>	<p>_____</p> <p>_____</p>	<p><input type="checkbox"/><input type="checkbox"/> years old</p>
<p>31. Liver disease? Do not include liver cancer.</p> <p><input type="checkbox"/> Yes →  <input type="checkbox"/> No (GO TO Q32)</p>	<p><input type="checkbox"/> Necrosis  <input type="checkbox"/> Cirrhosis  <input type="checkbox"/> Liver failure  <input type="checkbox"/> Fatty liver  <input type="checkbox"/> Other-specify:          _____          _____</p>	<p><input type="checkbox"/><input type="checkbox"/> years old</p>
<p>32. Lupus?</p> <p><input type="checkbox"/> Yes →  <input type="checkbox"/> No (GO TO Q33)</p>		<p><input type="checkbox"/><input type="checkbox"/> years old</p>
<p>33. Scleroderma?</p> <p><input type="checkbox"/> Yes →  <input type="checkbox"/> No (GO TO Q34)</p>		<p><input type="checkbox"/><input type="checkbox"/> years old</p>

<p>c. What is the name, address, and phone number of the doctor or other health care provider who diagnosed this condition?</p>	<p>d. Were you ever hospitalized for treatment of this condition?</p>	<p>e. What was the name and address of the hospital where you were first treated for this condition?</p>
<p>Doctor Name: _____</p>	<p><input type="checkbox"/> Yes →  <input type="checkbox"/> No (GO TO</p>	<p>Name: _____</p>



Survey ID# \_\_\_\_\_

Facility: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____ Phone Number: (____) ____ - _____	Q31)	Address: _____ _____ City: _____ State: _____ Zip Code: _____
Doctor Name: _____ Facility: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____ Phone Number: (____) ____ - _____	<input type="checkbox"/> Yes → <input type="checkbox"/> No (GO TO Q32)	Name: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____
Doctor Name: _____ Facility: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____ Phone Number: (____) ____ - _____	<input type="checkbox"/> Yes → <input type="checkbox"/> No (GO TO Q33)	Name: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____
Doctor Name: _____ Facility: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____ Phone Number: (____) ____ - _____	<input type="checkbox"/> Yes → <input type="checkbox"/> No (GO TO Q34)	Name: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____

Between the time you were first were stationed, employed, or living at Camp Lejeune or Camp Pendleton and now, were you told by a doctor or other health care provider that you had any of the following conditions?

	b. What was the name of the disease?	c. How old were you when you were first told this?
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Survey ID# \_\_\_\_\_

<p>34. Parkinson's disease?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No (GO TO Q35)</p>		<p><input type="text"/> <input type="text"/> years old</p>
<p>35. Multiple sclerosis (MS)?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No (GO TO Q36)</p>		<p><input type="text"/> <input type="text"/> years old</p>
<p>36. Amyotrophic Lateral Sclerosis (also known as ALS or "Lou Gehrig's Disease") or some other motor neuron disease?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No (GO TO Q37)</p>		<p><input type="text"/> <input type="text"/> years old</p>
<p>37. Aplastic anemia?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No (GO TO Q38)</p>		<p><input type="text"/> <input type="text"/> years old</p>

<p>c. What is the name, address, and phone number of the doctor or other health care provider who diagnosed this condition?</p>	<p>d. Were you ever hospitalized for treatment of this condition?</p>	<p>e. What was the name and address of the hospital where you were first treated for this condition?</p>
<p>Doctor Name: _____</p>	<p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No (GO TO _____)</p>	<p>Name: _____</p>

Survey ID# \_\_\_\_\_

Facility: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____ Phone Number: (____) ____-____	Q35)	Address: _____ _____ City: _____ State: _____ Zip Code: _____
Doctor Name: _____ Facility: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____ Phone Number: (____) ____-____	<input type="checkbox"/> Yes → <input type="checkbox"/> No (GO TO Q36)	Name: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____
Doctor Name: _____ Facility: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____ Phone Number: (____) ____-____	<input type="checkbox"/> Yes → <input type="checkbox"/> No (GO TO Q37)	Name: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____
Doctor Name: _____ Facility: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____ Phone Number: (____) ____-____	<input type="checkbox"/> Yes → <input type="checkbox"/> No (GO TO Q38)	Name: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____

38. Between the time you were first were stationed, employed, or living at Camp Lejeune or Camp Pendleton and now, were you told by a doctor or other health care provider that you had a persistent skin rash or dermatitis?

- Yes  
 No → **GO TO QUESTION 46 ON PAGE XX**

38a. Did you have hepatitis at the same time you had the skin rash or dermatitis?

Survey ID# \_\_\_\_\_

- Yes
- No

39. What was the name of the skin rash or dermatitis? \_\_\_\_\_

40. How old were you when you were first told this?  years old

41. What is the name, address, and phone number of the doctor or other health care provider who first diagnosed your skin rash or dermatitis?

Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

42. Were you ever hospitalized for treatment of your skin rash or dermatitis? If yes, please specify where you were first hospitalized for this skin rash or dermatitis.

Yes → Name of Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

No

43. How long did the skin rash last?  number

- ↓
- Days
  - Weeks
  - Months
  - Years

44. Where on your body did the skin rash occur? (Mark all that apply.)

- Head
- Face
- Arms
- Hands
- Chest
- Back

- Stomach
- Legs
- Feet
- Other-specify:

\_\_\_\_\_

Survey ID# \_\_\_\_\_

45. What were the symptoms of the skin rash? (Mark all that apply.)

- |  |  |
|--|--|
| <input type="checkbox"/> Redness                       | <input type="checkbox"/> Blisters                |
| <input type="checkbox"/> Swelling                      | <input type="checkbox"/> Fissures or cracks      |
| <input type="checkbox"/> Itching                       | <input type="checkbox"/> Oozing                  |
| <input type="checkbox"/> Dry skin with scaling/flaking | <input type="checkbox"/> Bleeding                |
| <input type="checkbox"/> Crusts                        | <input type="checkbox"/> Other-specify:<br>_____ |

46. Between the time you were first were stationed, employed, or living at Camp Lejeune or Camp Pendleton and now, were you told by a doctor or other health care provider that you were infertile? (Do not include your partner's infertility.)

- Yes  
 No → **GO TO OTHER HEALTH CONDITIONS ON PAGE XX**

47. What did your doctor or other health care provider tell you was the reason for your infertility?

- |   |  |
|---|--|
| <input type="checkbox"/> Fallopian tube damage or blockage                    | <input type="checkbox"/> Abnormal sperm          |
| <input type="checkbox"/> Endometriosis  | <input type="checkbox"/> Low sperm count         |
| <input type="checkbox"/> Advanced age   | <input type="checkbox"/> Impotence               |
| <input type="checkbox"/> Ovulation disorders/Polycystic Ovary Syndrome (PCOS) | <input type="checkbox"/> Unexplained infertility |
| <input type="checkbox"/> Uterine fibroids/Other uterus problems               | <input type="checkbox"/> Other-specify:<br>_____ |

48. How old were you when you were first told this?  years old

49. What is the name, address, and phone number of the doctor or other health care provider who first diagnosed your infertility?

Doctor Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

50. Were you ever hospitalized for treatment of your infertility? If yes, please specify where you were first hospitalized for this cancer.

- Yes → Name of Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_

Survey ID# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

No

### Other Health Conditions

51. Between the time you were first were stationed, employed, or living at Camp Lejeune or Camp Pendleton and now, have you had any other serious health problems that have not been covered above? If yes, please list them below.

Yes

1: \_\_\_\_\_

2: \_\_\_\_\_

3: \_\_\_\_\_

No

**MALE RESPONDENTS - GO TO OCCUPATIONAL HISTORY SECTION ON PAGE XX**

**FEMALE RESPONDENTS - CONTINUE WITH REPRODUCTIVE HISTORY SECTION**

### Reproductive History (WOMEN ONLY)

52. Between the time you were first were stationed, employed, or living at Camp Lejeune or Camp Pendleton and now, were you told by a doctor or other health care provider that you have endometriosis?

Yes

No → **GO TO QUESTION 56 ON PAGE XX**

53. How old were you when you were first told this?  years old

54. What is the name, address, and phone number of the doctor or other health care provider who diagnosed your endometriosis?

Doctor Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

55. Were you ever hospitalized for treatment of your endometriosis?

Survey ID# \_\_\_\_\_

- Yes → Name of Hospital: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
- No

56. Have you ever been pregnant?

- Yes  
 No → **GO TO OCCUPATIONAL HISTORY SECTION ON PAGE XX**

57. Have you ever had a pregnancy that resulted in a live birth?

- Yes  
 No

58. Were you pregnant during the time you lived or worked at Camp Lejeune or Camp Pendleton?

- Yes  
 No → **GO TO OCCUPATIONAL HISTORY SECTION ON PAGE XX**

The following questions ask about each pregnancy that occurred during the time that you lived or worked at Camp Lejeune or Camp Pendleton. Please do not include any pregnancies that were not during your time at Camp Lejeune or Camp Pendleton.

	<b>59. When did this pregnancy end? (month/year)</b>	<b>60. What was the outcome of this pregnancy?</b>	<b>61. Did this pregnancy involve a birth defect?</b>
Pregnancy #1	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Live birth of single child <input type="checkbox"/> Live birth of multiple children <input type="checkbox"/> Tubal pregnancy <input type="checkbox"/> Elective abortion <input type="checkbox"/> Miscarriage or stillbirth → How many weeks were you when the pregnancy ended?	<input type="checkbox"/> Yes <input type="checkbox"/> No ↓ If yes, what is the name of the birth defect? _____ _____

		<input type="checkbox"/> <input type="checkbox"/> weeks Did you have a positive pregnancy test before the miscarriage/stillbirth occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the miscarriage/stillbirth confirmed by a doctor or other health care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pregnancy #2	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Live birth of single child <input type="checkbox"/> Live birth of multiple children <input type="checkbox"/> Tubal pregnancy <input type="checkbox"/> Elective abortion <input type="checkbox"/> Miscarriage or stillbirth → How many weeks were you when the pregnancy ended? <input type="checkbox"/> <input type="checkbox"/> weeks Did you have a positive pregnancy test before the miscarriage/stillbirth occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the miscarriage/stillbirth confirmed by a doctor or other health care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes → <input type="checkbox"/> No ↓ If yes, what is the name of the birth defect? _____ _____

	59. When did this pregnancy end? (month/year)	60. What was the outcome of this pregnancy?	61. Did this pregnancy involve a birth defect?
Pregnancy #3	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Live birth of single child <input type="checkbox"/> Live birth of multiple children <input type="checkbox"/> Tubal pregnancy <input type="checkbox"/> Elective abortion <input type="checkbox"/> Miscarriage or stillbirth → How many weeks were you when the pregnancy ended? <input type="checkbox"/> <input type="checkbox"/> weeks Did you have a positive pregnancy test before the miscarriage/stillbirth occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the miscarriage/stillbirth confirmed by a doctor or other health care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes → <input type="checkbox"/> No ↓ If yes, what is the name of the birth defect? _____ _____



<p>Pregnancy #4</p>	<p><input type="text"/> <input type="text"/> /  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p><input type="checkbox"/> Live birth of single child  <input type="checkbox"/> Live birth of multiple children  <input type="checkbox"/> Tubal pregnancy  <input type="checkbox"/> Elective abortion  <input type="checkbox"/> Miscarriage or stillbirth</p> <p>How many weeks were you when the pregnancy ended?  <input type="text"/> <input type="text"/> weeks</p> <p>Did you have a positive pregnancy test before the miscarriage/stillbirth occurred?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was the miscarriage/stillbirth confirmed by a doctor or other health care provider?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes  <input type="checkbox"/> No</p> <p>If yes, what is the name of the birth defect?  <hr/>  <hr/></p>
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**Occupational History**

The next questions ask about your work experiences – paid or military – between the time you were first stationed, employed, or living at Camp Lejeune or Camp Pendleton and now. This includes any part-time and full-time jobs, jobs at home, jobs on base, and jobs on a farm that lasted at least one month or longer.

**If you never worked, please check this box  and go to Question 75 ON PAGE XX.**

Survey ID# \_\_\_\_\_

**Job #1**

62. Starting with the time you were first stationed, employed or living at Camp Lejeune or Camp Pendleton, what was the name and location of the first company or organization you worked for?

Name of company/organization: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

63. If the job was on base at Camp Lejeune or Camp Pendleton, please specify the area on base where you worked (that is, address or building number).

\_\_\_\_\_

64. In what month and year did you start this job?	<table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td></tr></table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	m	m	y	y	y	y
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65. In what month and year did you end this job?	<table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td></tr></table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	m	m	y	y	y	y
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m	m	y	y	y	y								
66. What was your job title?	_____												
67. What did that company/organization make or do?	_____ _____												
68. What were your main activities and duties on this job?	_____ _____ _____												
69. Did you usually work part-time or full-time?	<input type="checkbox"/> Part-time (Part-time is less than 35 hours per week) <input type="checkbox"/> Full-time												
70. Did you work with pesticides, herbicides, fungicides, insecticides, or rat poison?  <input type="checkbox"/> Yes → <input type="checkbox"/> No	What is the name of the chemical(s) you worked with? _____  On average, how many hours per week were you around these products? Enter '00' if less than 1 hour. <input type="text"/> <input type="text"/> hours per week												

**Job #1 (cont.)**

<p>71. Did you work with radiation such as x-rays, radar, or microwaves?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What kind of radiation did you work with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="checkbox"/><input type="checkbox"/> hours per week</p>
<p>72. Did you work with heavy metals such as lead, mercury, or nickel?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What is the name of the metal(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="checkbox"/><input type="checkbox"/> hours per week</p>
<p>73. Did you work with solvents such as paint thinners, paints, glues, metal degreasing agents, auto fluids, dry cleaning agents, toluene, carbon disulfide, trichloroethylene, or carbon tetrachloride?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What is the name of the solvent(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="checkbox"/><input type="checkbox"/> hours per week</p>

74. Did you have any other jobs after this one?

Yes → **GO TO JOB #2**

No → **GO TO QUESTION 75 ON PAGE XX**

Survey ID# \_\_\_\_\_

**Job #2**

62. What was the name and location of the next company or organization you worked for?

Name of company/organization: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

63. If the job was on base at Camp Lejeune or Camp Pendleton, please specify the area on base where you worked (that is, address or building number).  
\_\_\_\_\_

64. In what month and year did you start this job?	<table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td>/</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>m</td><td>m</td><td></td><td>y</td><td>y</td><td>y</td><td>y</td><td></td></tr></table>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	m	m		y	y	y	y	
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65. In what month and year did you end this job?	<table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td>/</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>m</td><td>m</td><td></td><td>y</td><td>y</td><td>y</td><td>y</td><td></td></tr></table>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	m	m		y	y	y	y	
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68. What were your main activities and duties on this job?	_____ _____ _____																
69. Did you usually work part-time or full-time?	<input type="checkbox"/> Part-time (Part-time is less than 35 hours per week) <input type="checkbox"/> Full-time																
70. Did you work with pesticides, herbicides, fungicides, insecticides, or rat poison?  <input type="checkbox"/> Yes → <input type="checkbox"/> No	What is the name of the chemical(s) you worked with? _____  On average, how many hours per week were you around these products? Enter '00' if less than 1 hour. <input type="text"/> <input type="text"/> hours per week																

**Job #2 (cont.)**

<p>71. Did you work with radiation such as x-rays, radar, or microwaves?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What kind of radiation did you work with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="text"/><input type="text"/> hours per week</p>
<p>72. Did you work with heavy metals such as lead, mercury, or nickel?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What is the name of the metal(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="text"/><input type="text"/> hours per week</p>
<p>73. Did you work with solvents such as paint thinners, paints, glues, metal degreasing agents, auto fluids, dry cleaning agents, toluene, carbon disulfide, trichloroethylene, or carbon tetrachloride?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What is the name of the solvent(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="text"/><input type="text"/> hours per week</p>

74. Did you have any other jobs after this one?

Yes → **GO TO JOB #3**

No → **GO TO QUESTION 75 ON PAGE XX**

**Job #3**

Survey ID# \_\_\_\_\_

62. What was the name and location of the next company or organization you worked for?

Name of company/organization: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

63. If the job was on base at Camp Lejeune or Camp Pendleton, please specify the area on base where you worked (that is, address or building number).

\_\_\_\_\_

64. In what month and year did you start this job?	<table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td></tr></table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	m	m	y	y	y	y
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65. In what month and year did you end this job?	<table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>m</td><td>m</td><td>y</td><td>y</td><td>y</td><td>y</td></tr></table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	m	m	y	y	y	y
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68. What were your main activities and duties on this job?	_____ _____ _____												
69. Did you usually work part-time or full-time?	<input type="checkbox"/> Part-time (Part-time is less than 35 hours per week) <input type="checkbox"/> Full-time												
70. Did you work with pesticides, herbicides, fungicides, insecticides, or rat poison?  <input type="checkbox"/> Yes → <input type="checkbox"/> No	What is the name of the chemical(s) you worked with? _____  On average, how many hours per week were you around these products? Enter '00' if less than 1 hour. <input type="text"/> <input type="text"/> hours per week												

**Job #3 (cont.)**

<p>71. Did you work with radiation such as x-rays, radar, or microwaves?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What kind of radiation did you work with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="checkbox"/><input type="checkbox"/> hours per week</p>
<p>72. Did you work with heavy metals such as lead, mercury, or nickel?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What is the name of the metal(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="checkbox"/><input type="checkbox"/> hours per week</p>
<p>73. Did you work with solvents such as paint thinners, paints, glues, metal degreasing agents, auto fluids, dry cleaning agents, toluene, carbon disulfide, trichloroethylene, or carbon tetrachloride?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What is the name of the solvent(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="checkbox"/><input type="checkbox"/> hours per week</p>

74. Did you have any other jobs after this one?

Yes → **GO TO JOB #4**

No → **GO TO QUESTION 75 ON PAGE XX**

**Job #4**

62. What was the name and location of the next company or organization you worked for?

Name of company/organization: \_\_\_\_\_

Survey ID# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

63. If the job was on base at Camp Lejeune or Camp Pendleton, please specify the area on base where you worked (that is, address or building number).

\_\_\_\_\_

64. In what month and year did you start this job?	<table border="0"><tr><td><input type="text"/></td><td><input type="text"/></td><td>/</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>m</td><td>m</td><td></td><td>y</td><td>y</td><td>y</td><td>y</td><td></td></tr></table>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	m	m		y	y	y	y	
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65. In what month and year did you end this job?	<table border="0"><tr><td><input type="text"/></td><td><input type="text"/></td><td>/</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>m</td><td>m</td><td></td><td>y</td><td>y</td><td>y</td><td>y</td><td></td></tr></table>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	m	m		y	y	y	y	
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69. Did you usually work part-time or full-time?	<input type="checkbox"/> Part-time (Part-time is less than 35 hours per week) <input type="checkbox"/> Full-time																
70. Did you work with pesticides, herbicides, fungicides, insecticides, or rat poison?  <input type="checkbox"/> Yes → <input type="checkbox"/> No	What is the name of the chemical(s) you worked with? _____  On average, how many hours per week were you around these products? Enter '00' if less than 1 hour. <input type="text"/> <input type="text"/> hours per week																



**Job #4 (cont.)**

<p>71. Did you work with radiation such as x-rays, radar, or microwaves?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What kind of radiation did you work with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour. <input type="text"/> <input type="text"/> hours per week</p>
<p>72. Did you work with heavy metals such as lead, mercury, or nickel?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What is the name of the metal(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour. <input type="text"/> <input type="text"/> hours per week</p>
<p>73. Did you work with solvents like paint thinners, paints, glues, metal degreasing agents, auto fluids, dry cleaning agents, toluene, carbon disulfide, trichloroethylene, or carbon tetrachloride?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What is the name of the solvent(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour. <input type="text"/> <input type="text"/> hours per week</p>

74. Did you have any other jobs after this one?

Yes → **GO TO JOB #5**

No → **GO TO QUESTION 75 ON PAGE XX**

Survey ID# \_\_\_\_\_

**Job #5**

62. What was the name and location of the next company or organization you worked for?

Name of company/organization: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

63. If the job was on base at Camp Lejeune or Camp Pendleton, please specify the area on base where you worked (that is, address or building number).  
\_\_\_\_\_

64. In what month and year did you start this job?	<table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td>/</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>m</td><td>m</td><td></td><td>y</td><td>y</td><td>y</td><td>y</td><td></td></tr></table>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	m	m		y	y	y	y	
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m	m		y	y	y	y											
65. In what month and year did you end this job?	<table border="1"><tr><td><input type="text"/></td><td><input type="text"/></td><td>/</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td>m</td><td>m</td><td></td><td>y</td><td>y</td><td>y</td><td>y</td><td></td></tr></table>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	m	m		y	y	y	y	
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66. What was your job title?	_____																
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70. Did you work with pesticides, herbicides, fungicides, insecticides, or rat poison?  <input type="checkbox"/> Yes → <input type="checkbox"/> No	What is the name of the chemical(s) you worked with? _____  On average, how many hours per week were you around these products? Enter '00' if less than 1 hour. <input type="text"/> <input type="text"/> hours per week																

**Job #5 (cont.)**

<p>71. Did you work with radiation such as x-rays, radar, or microwaves?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What kind of radiation did you work with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour. <input type="text"/> <input type="text"/> hours per week</p>
<p>72. Did you work with heavy metals such as lead, mercury, or nickel?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What is the name of the metal(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour. <input type="text"/> <input type="text"/> hours per week</p>
<p>73. Did you work with solvents such as paint thinners, paints, glues, metal degreasing agents, auto fluids, dry cleaning agents, toluene, carbon disulfide, trichloroethylene, or carbon tetrachloride?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p>	<p>What is the name of the solvent(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour. <input type="text"/> <input type="text"/> hours per week</p>

74. Did you have any other jobs after this one?





Yes → **GO TO OTHER JOBS**

No → **GO TO QUESTION 75 ON PAGE XX**

**Other Jobs**

Survey ID# \_\_\_\_\_

Please answer the following questions about all of the other jobs you have held since the last job you just reported.

<p>70. In any of these jobs, did you work with pesticides, herbicides, fungicides, insecticides, or rat poison?</p> <p><input type="checkbox"/> Yes  <input type="checkbox"/> No</p>	<p>What is the name of the chemical(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="checkbox"/><input type="checkbox"/> hours per week</p>
<p>71. In any of these jobs, did you work with radiation such as x-rays, radar, or microwaves?</p> <p><input type="checkbox"/> Yes  <input type="checkbox"/> No</p>	<p>What kind of radiation did you work with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="checkbox"/><input type="checkbox"/> hours per week</p>
<p>72. In any of these jobs, did you work with heavy metals such as lead, mercury, or nickel?</p> <p><input type="checkbox"/> Yes  <input type="checkbox"/> No</p>	<p>What is the name of the metal(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="checkbox"/><input type="checkbox"/> hours per week</p>
<p>73. In any of these jobs, did you work with solvents such as paint thinners, paints, glues, metal degreasing agents, auto fluids, dry cleaning agents, toluene, carbon disulfide, trichloroethylene, or carbon tetrachloride?</p> <p><input type="checkbox"/> Yes  <input type="checkbox"/> No</p>	<p>What is the name of the solvent(s) you worked with?</p> <p>_____</p> <p>On average, how many hours per week were you around these products? Enter '00' if less than 1 hour.</p> <p><input type="checkbox"/><input type="checkbox"/> hours per week</p>

75. Were you stationed in Vietnam between 1965 and 1971?  
 Yes

Survey ID# \_\_\_\_\_

No → **GO TO SMOKING HISTORY SECTION BELOW**

76. Which year(s) were you in Vietnam? (Mark all that apply.)

- |                               |                               |
|-------------------------------|-------------------------------|
| <input type="checkbox"/> 1965 | <input type="checkbox"/> 1969 |
| <input type="checkbox"/> 1966 | <input type="checkbox"/> 1970 |
| <input type="checkbox"/> 1967 | <input type="checkbox"/> 1971 |
| <input type="checkbox"/> 1968 |                               |

77. In total, how many months were you in Vietnam between 1965 and 1971?

months

78. Did you ever come into contact with herbicides while you were in Vietnam? For example, did you inhale herbicides or get herbicides on your skin or clothing?

Yes (describe how you were exposed)

\_\_\_\_\_

No

Not sure

### Smoking History

79. Have you ever smoked cigarettes regularly?

Yes

No → **GO TO QUESTION 86 ON PAGE XX**

80. Do you smoke cigarettes now?

Yes

No → **GO TO QUESTION 83 ON PAGE XX**

81. On average, over all the years you have smoked, how many cigarettes a day did you smoke (1 pack=20 cigarettes)?

cigarettes per day

82. In total, how many years have you smoked, excluding any times you may have quit?

years - **GO TO QUESTION 86 ON PAGE XX**

Survey ID# \_\_\_\_\_

83. How old were you the last time you quit smoking cigarettes?  years old

84. On average, when you were smoking, about how many cigarettes a day did you smoke (1 pack = 20 cigarettes)?

cigarettes per day

85. In total, how many years did you smoke, excluding any times you may have quit?

years

86. Have you ever used any other tobacco products regularly (such as chewing tobacco, smokeless tobacco, cigars, a pipe, etc.)?

Yes

No → **GO TO QUESTION 89**

87. Do you currently use these tobacco products regularly?

Yes

No

88. Which of the following tobacco products have you used or do you currently use on a regular basis? (Mark all that apply.)

Chewing tobacco

Smokeless tobacco

Pipe

Cigars

Other-specify: \_\_\_\_\_

89. Have you ever lived for more than 1 year with someone who smoked on a daily basis?

Yes

No → **GO TO ALCOHOL HISTORY SECTION ON PAGE XX**

90. How many years did you live with someone who smoked on a daily basis?

1-3 years

7-9 years

13-15 years

4-6 years

10-12 years

16 or more years

91. During most of this time, how many people living with you smoked on a daily basis?

1 person

Survey ID# \_\_\_\_\_

- 2 persons
- More than 2 persons

### Alcohol History

The following questions relate to your use of alcohol.

92. Have you ever had a drink of alcohol?

- Yes
- No → **GO TO DEMOGRAPHICS SECTION ON PAGE XX**

93. At what age did you start drinking alcohol?  years old

94. Do you drink alcoholic beverages now?

- Yes
- No → **GO TO QUESTION 98 ON PAGE XX**

95. On average, how often do you drink alcoholic beverages? (Mark one.)

- Almost every day
- 2 to 4 times a week
- 1 time a week
- 1 to 3 times a month
- Less than once a month

A "serving" of alcohol equals any of the following: 1 can of beer, 1 glass of wine, 1 can or bottle of wine cooler, or 1 shot of liquor.

96. When you drink, about how many servings do you usually have?

- servings

97. Is there a time in the past that you drank significantly more than you usually drink now?

- Yes
- No } **GO TO DEMOGRAPHICS**

98. How old were you when you stopped drinking alcoholic beverages?  years old

99. On average, how often did you drink alcoholic beverages? (Mark one.)

Survey ID# \_\_\_\_\_

- Almost every day
- 2 to 4 times a week
- 1 time a week
- 1 to 3 times a month
- Less than once a month

100. When you drank, about how many servings did you usually have?

servings

### Demographics

A. What race do you consider yourself to be? (Mark all that apply.)

- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Black or African American
- White
- Some other race-specify: \_\_\_\_\_

B. Do you consider yourself to be Hispanic or Latino?

- Yes
- No

C. What is the highest level of education you have completed? (Mark one.)

- Less than a high school diploma
- High school diploma or GED
- Some college, Technical/Vocational School, or Associate's Degree
- Bachelor's degree (4 years of college) or higher

D. What is your Social Security Number (SSN)? --

(The authority for collecting your SSN is the National Defense Authorization Act for Fiscal Year 2008. Your SSN will be kept private. We do not plan to share this information with anyone other than ATSDR staff. We will use your SSN for identity verification purposes and to link with your medical data.)

Please provide your:

Home Phone Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_  N/A

Cell Phone Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_  N/A

E-Mail address: \_\_\_\_\_

Please provide the contact information of a friend or family member who will always know your



Survey ID# \_\_\_\_\_

whereabouts in case we need to contact you in the future.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apartment Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ - \_\_\_\_\_ Country:

Home Phone Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_  N/A

Cell Phone Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_  N/A

Relationship to you (sibling, child, friend, etc.): \_\_\_\_\_

### **Conclusion**

**The Agency for Toxic Substances and Disease Registry (ATSDR) would like to sincerely thank you for your time and effort. Your contributions to this important health survey will help us learn more about ways to improve health and prevent disease in the future.**

**Please help us by reviewing each page again to make sure that you:**

- **Did not skip any questions, and**
- **Marked out any wrong answers and entered an X next to the correct answer.**

**If you've answered "Yes" to any of the conditions listed below, please read and sign the Medical Release Form included in this package, so we can obtain your medical records from your doctor or health care provider to confirm this condition.**

- **Any cancer**
- **Parkinson's disease**
- **Kidney disease or Kidney failure**
- **Liver disease**
- **Lupus**
- **Aplastic anemia**
- **Persistent skin rashes or dermatitis**
- **Scleroderma**
- **Infertility**
- **Endometriosis**
- **Multiple Sclerosis (MS)**
- **Amyotrophic Lateral Sclerosis (ALS)**