Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/xxxx

Airborne Particle Monitoring Time-Diary Data and Instructions

Time Diary Instructions

In this study, we need information on what is going on in your home to be able to make sense of the air monitoring data. Using ONE **Daily Air Diary Form** EACH DAY, we want you to check the following things: (1) When you or other people who live here are home; (2) When and where you smell Tobacco Smoke; (3) If there are any other activities that may make smoke or particles; and (4) if you do anything to increase air movement (like open a window or use a fan) and for how long.

Fill out ONE Daily Air Diary form each day. ONE resident of the home will be designated to fill out the form each day. This person will be called the "respondent" in these instructions. In general, this will be the person who completed the survey. If you (the "respondent") are not home during one of the time periods, please consult with other people who were home when you complete the diary for that time period.

You should have TEN copies of the **Daily Air Diary Form** (SEVEN days plus THREE extras)

There are four rows of the form for you to fill out. Each row matches a different 6-hour time period, starting at midnight. For example, the first row is for the "midnight to 6 AM" time period and the second row is for the "6AM to NOON" time period, and so on. Each row asks you to give the exact same information as the other rows – just the time period is different.

Please use the following directions to help you fill out all 4 rows the form. There are a total of SEVEN columns of information for each row.

Column ONE: Please check the "Yes, At Home" circle if you ("the respondent") were home for at least 3 hours during the time period OR check "No, Not at Home" if you were not at home for at least 3 hours. Also check the boxes for "Adult Residents Home?" and "Other Children Home?" if any adults or any children were home for at least 3 hours.

Column TWO: Did ANYONE in the house smell tobacco smoke during this time period? If so, check the "Yes" circle, otherwise check "No". Check "Don't know" only if you were not at home and others could not help you answer this question.

Column THREE: If tobacco smoke was smelled in the house by ANYONE in this time period, check the circle corresponding to the room that had the STRONGEST tobacco smoke smell. If the room is not

listed, check the “Other” circle and write in the room where the tobacco smoke smell was STRONGEST. If no tobacco smoke was smelled, then check the “No Tobacco Smell/Don’t Know” circle. Check “Don’t know” only if you were not at home and others could not help you answer this question.

Column FOUR: Did ANYONE in the house cook with the stove or oven during this time period? If so, check ALL the boxes corresponding to types of cooking that occurred. If no cooking occurred OR if you were not at home and others could not help you answer this question, DO NOT check any boxes.

Column FIVE: Did ANYONE do any other activities in the house that generated particles in the air? For example, did ANYONE in the house burn incense, light a wood fire, or dust the furniture? If so, then check all the boxes corresponding to activities that ANYONE did during the time period. If the activity is not listed, then check the “Other” box and write in the activity. If none of these activities occurred OR if you were not at home and others could not help you answer this question, DO NOT check any boxes.

Column SIX: Did ANYONE do anything to increase the air movement (ventilation) in the house during this time period that LASTED 5 MINUTES OR MORE? For example, did anyone open a window to air out the house, or did anyone turn on the central air system? If so, then check all the boxes corresponding to activities that ANYONE did during the time period.

Column SEVEN: If ANYONE did anything to increase the air movement (ventilation) in the house during this time period for 5 OR MORE MINUTES, then check the circle corresponding to the APPROXIMATE TOTAL time during which any type increased air movement occurred. For example, if the kitchen exhaust fan was on for 10 minutes, then check “Under 1 hour”, if one or more windows were open for 15 minutes AND a ceiling fan was on for 30 min OVERLAPPING AT THE SAME time, then check the circle for “Under 1 hour”. If the window was open for 30 minutes and the ceiling fan was on for 1 hour at a SEPARATE time, then check the circle for “1 to 2 hours”. For the central air system, include ALL time that the thermostat was set to continually cool or heat the home – even if the air came on only intermittently during this period. If no activities were done by ANYONE that increased air movement, check the “No increased movement” circle. If you were not at home and others could not help you answer this question, DO NOT check any boxes.

SAMPLE DAILY AIR DIARY

Please fill in the Date (MM/DD/YY) and Day of Week. Please fill out the form for activities that ANYONE did on this day.

Daily Air Diary
rev 24-May-2012 (NK)

MM/DD/YY: _____ Day of Week: _____ Home ID#: LAMUH-A0234

TIME OF DAY	OCCUPANCY	TOBACCO SMOKE SMELL?	ROOM WITH STRONGEST TOBACCO SMOKE SMELL	COOKING WITH STOVE OR OVEN?	OTHER PARTICLE ACTIVITIES?	INCREASED AIR MOVEMENT?	TIME OF INCREASED AIR MOVEMENT
	Respondent home at least 3 hours in time period? Any other adults or children home at least 3 hours in time period?	Did any tobacco smell occur during time period?	If any tobacco smell, check ONE room with strongest smell	Check ALL cooking that occurred at any time during time period	Check ALL other particle activities that occurred at any time during time period	Check ALL increased air movement activity that occurred for 5 MINUTES OR MORE during time period	Check the TOTAL TIME that ANY TYPE of increased air movement occurred
Midnight to 6 AM	☐ Respondent Home? ☐ Other Adults Home? ☐ Any Children Home?	○ Yes ○ No ○ Don't Know	○ No Smell or Don't Know ○ LIV ○ BED1 ○ KIT ○ BED2 ○ DIN ○ BED3 ○ BATH1 ○ BATH2 ○ Other Room, Specify:	☐ Used Propane/Gas ☐ Used Oil to Grill/Fry ☐ Boiled/Simmered ☐ Baked ☐ Broiled ☐ Microwaved ☐ Burned Food	☐ Dusting/Sweeping ☐ Incense/Candle ☐ Spray Can/Bottle ☐ Wood Stove/Fire ☐ Humidifier/Steam ☐ Woodworking/Drywall ☐ Other, Specify:	☐ Window/Door Left Open ☐ Window AC/Fan On ☐ Kitchen Exhaust Fan On ☐ Bathroom Exhaust Fan On ☐ Ceiling/Directional Fan On ☐ Central Air/HVAC On ☐ Air Purifier Fan On	○ No Increased Movement ○ under 1 hour ○ 1+ to 2 hours ○ 2+ to 3 hours ○ 3+ hours
6 AM to Noon	☐ Respondent Home? ☐ Other Adults Home? ☐ Any Children Home?	○ Yes ○ No ○ Don't Know	○ No Smell or Don't Know ○ LIV ○ BED1 ○ KIT ○ BED2 ○ DIN ○ BED3 ○ BATH1 ○ BATH2 ○ **Other Room, Specify:**	☐ Used Propane/Gas ☐ Used Oil to Grill/Fry ☐ Boiled/Simmered ☐ Baked ☐ Broiled ☐ **Microwaved** ☐ Burned Food	☐ Dusting/Sweeping ☐ Incense/Candle ☐ Spray Can/Bottle ☐ Wood Stove/Fire ☐ Humidifier/Steam ☐ Woodworking/Drywall ☐ Other, Specify:	☐ Window/Door Left Open ☐ Window AC/Fan On ☐ **Kitchen Exhaust Fan On** ☐ **Bathroom Exhaust Fan On** ☐ Ceiling/Directional Fan On ☐ Central Air/HVAC On ☐ Air Purifier Fan On	○ No Increased Movement ○ under 1 hour ○ 1+ to 2 hours ○ 2+ to 3 hours ○ 3+ hours
Noon to 6 PM	☐ Respondent Home? ☐ Other Adults Home? ☐ Any Children Home?	○ Yes ○ No ○ Don't Know	○ No Smell or Don't Know ○ LIV ○ BED1 ○ KIT ○ BED2 ○ DIN ○ BED3 ○ BATH1 ○ BATH2 ○ **Other Room, Specify:**	☐ Used Propane/Gas ☐ Used Oil to Grill/Fry ☐ Boiled/Simmered ☐ Baked ☐ Broiled ☐ **Microwaved** ☐ Burned Food	☐ Dusting/Sweeping ☐ Incense/Candle ☐ Spray Can/Bottle ☐ Wood Stove/Fire ☐ Humidifier/Steam ☐ Woodworking/Drywall ☐ Other, Specify:	☐ Window/Door Left Open ☐ Window AC/Fan On ☐ **Kitchen Exhaust Fan On** ☐ **Bathroom Exhaust Fan On** ☐ Ceiling/Directional Fan On ☐ Central Air/HVAC On ☐ Air Purifier Fan On	○ No Increased Movement ○ under 1 hour ○ 1+ to 2 hours ○ 2+ to 3 hours ○ 3+ hours
6 PM to Midnight	☐ Respondent Home? ☐ Other Adults Home? ☐ Any Children Home?	○ Yes ○ No ○ Don't Know	○ No Smell or Don't Know ○ LIV ○ BED1 ○ KIT ○ BED2 ○ DIN ○ BED3 ○ BATH1 ○ BATH2 ○ **Other Room, Specify:**	☐ Used Propane/Gas ☐ Used Oil to Grill/Fry ☐ Boiled/Simmered ☐ Baked ☐ Broiled ☐ **Microwaved** ☐ Burned Food	☐ Dusting/Sweeping ☐ Incense/Candle ☐ Spray Can/Bottle ☐ Wood Stove/Fire ☐ Humidifier/Steam ☐ Woodworking/Drywall ☐ Other, Specify:	☐ Window/Door Left Open ☐ Window AC/Fan On ☐ **Kitchen Exhaust Fan On** ☐ **Bathroom Exhaust Fan On** ☐ Ceiling/Directional Fan On ☐ Central Air/HVAC On ☐ Air Purifier Fan On	○ No Increased Movement ○ under 1 hour ○ 1+ to 2 hours ○ 2+ to 3 hours ○ 3+ hours