**INDIUM FACILITY QUESTIONNAIRE**

Today’s Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Day) (Year)

**Section I: Identification and Demographic Information**

Your Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

(Last name) (First name) (MI)

Your Mailing Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Number, Street, and/or Rural Route)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip Code)

Your Home Telephone Number: ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

Cell phone ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

*If you move, is there someone who would know how to contact you?*

Contact’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

(Last name) (First name) (MI)

Contact’s Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact’s Mailing Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Number, Street, and/or Rural Route)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip Code)

Contact’s Telephone Number: ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

Cell phone ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

1. Date of Birth: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Day) (Year)

2. Sex: 1.\_\_\_\_ Male 2. \_\_\_\_ Female

1. What is your ethnicity?

1. Hispanic or Latino \_\_\_\_

0. Not Hispanic or Latino\_\_\_

4. Choose one or more of the following categories to describe your race:

1. American Indian or Alaska Native

2. Asian

3. Black or African American

4. Native Hawaiian or Other Pacific Islander

5. White

**Section II. Health Information**

These questions pertain mainly to your chest. Please answer Yes or No if possible. If you are in doubt about whether your answer is Yes or No, answer No.

5a. Do you usually have a cough? 1. Yes \_\_\_ 0. No \_\_\_

(Count a cough with first smoke or on first going   
out-of-doors. Exclude clearing of throat.)

**IF YES:**

5b. When did this cough start? \_\_\_\_\_\_ Month \_\_\_\_\_Year

5c. Do you usually cough on most days for   
**3 consecutive months or more** during the year? 1. Yes \_\_\_ 0. No \_\_\_

6a. Do you usually bring up phlegm from your chest? 1. Yes \_\_\_ 0. No \_\_\_

(Count phlegm with the first smoke or on first going out-of-doors.   
Exclude phlegm from the nose. Count swallowed phlegm)

**IF YES:**

6b. When did this trouble with phlegm start? \_\_\_\_\_\_ Month \_\_\_\_\_Year

7a. Are you troubled by shortness of breath when

hurrying on level ground or walking up a slight hill? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

7b. Do you have to walk slower than people of your

age on level ground because of breathlessness? 1. Yes \_\_\_ 0. No \_\_\_

7c. Do you ever have to stop for breath when walking

at your own pace on level ground? 1. Yes \_\_\_ 0. No \_\_\_

7d. When did this shortness of breath start? \_\_\_\_\_\_ Month \_\_\_\_\_Year

8a. Have you had wheezing or whistling in your chest

at any time in the last **12 months**? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

8b. When did this wheezing or whistling start? \_\_\_\_\_\_ Month \_\_\_\_\_Year

8c. When you are away from this plant on days off

or on vacation, is this wheezing or whistling: 1.\_\_\_ Same

2.\_\_\_ Worse

3.\_\_\_ Better

8d. Apart from when you have a cold, does   
your chest ever sound wheezy or whistling? 1. Yes \_\_\_ 0. No \_\_\_

9a. Have you had a feeling of tightness in your chest

at any time in the last **12 months**? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

9b. Have you woken up with a feeling of tightness in your chest

at any time in the last **12 months**? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

9c. When did this awakening with a feeling of tightness in your chest start?

\_\_\_\_ Month \_\_\_\_\_Year

9d. When you are away from this plant on days off

or on vacation, is this awakening with a feeling of tightness in your chest: 1.\_\_\_ Same

2.\_\_\_ Worse

3.\_\_\_ Better

10a. Have you had an attack of asthma in the last 12 months? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES**:

10b. When did these attacks of asthma start? \_\_\_\_\_\_\_ Month \_\_\_\_\_Year

10c. When you are away from this plant on days off

or on vacation, are your attacks of asthma: 1.\_\_\_ Same

2.\_\_\_ Worse

3.\_\_\_ Better

11a. Are you currently taking any medicine (including inhalers,

aerosols, or tablets) for asthma? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES**:

11b. When did you start using medicine for asthma? \_\_\_\_\_\_ Month \_\_\_\_\_Year

11c.When you are away from this plant on days off 1.\_\_\_ Same

or on vacation, are your attacks of asthma: 2.\_\_\_ Worse

3.\_\_\_ Better

12a. Have you had any unusual tiredness or fatigue   
 during the last 12 months? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

12b. When did this tiredness or fatigue start? \_\_\_\_\_\_ Month \_\_\_\_\_Year

13a. Has a doctor ever told you that you had asthma? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

13b. When were you first told you had asthma? \_\_\_\_\_\_ Month \_\_\_\_\_Year

13c. Do you still have asthma? 1. Yes \_\_\_ 0. No \_\_\_

13d. If you no longer have asthma, how old were you   
 when your asthma stopped? \_\_\_\_\_\_ Age stopped

14a. Has a doctor ever told you that you had chronic bronchitis? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

14b.When were you first told you had chronic bronchitis? \_\_\_\_\_\_ Month \_\_\_\_\_Year

14c. Do you still have chronic bronchitis? 1. Yes \_\_\_ 0. No \_\_\_

15a. Has a doctor ever told you that you had emphysema? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

15b. When were you first told you had emphysema? \_\_\_\_\_\_ Month \_\_\_\_\_Year

16a. Has a doctor ever told you that you had COPD? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

16b. When were you first told you had COPD? \_\_\_\_\_\_ Month \_\_\_\_\_Year

17a. Has a doctor ever told you that you had

lung scarring or fibrosis? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

17b. When were you first told you had lung scarring or fibrosis? \_\_\_\_\_\_ Month \_\_\_\_\_Year

**Section III. Work Information**

Next, we are going to ask about your work history.

18. Please list all of the jobs you performed while at the facility on Sims Avenue or at the previous location on Harris Avenue. We want you to include any work you may have done at either of these locations prior to Umicore’s ownership in 2002 and any work as a temporary or contract employee. We will start with your first job and continue through to your most recent job.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Job Number | Department | Job Title | Start Date  (mm/yyyy) | End Date  (mm/yyyy) | Type of employee (Contract/Temporary/Umicore) | Major Work Area | Machines or tools used | Tasks performed | Materials or products handled |
| 1 |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |

For each job listed, ask:

18a. What other departments or work areas did you work in during this time period?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For current job, ask:

18b. Do you wear a respirator in this job? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

18c. How often did you wear the respirator:

1. Less than daily
2. Daily, less than 2 hours per day
3. Daily, 2 to 4 hours per day
4. Daily, over 4 hours per day

18d. For what tasks do you wear the respirator?

18e. Do you use different respirators for different tasks? 1. Yes \_\_\_ 0. No \_\_\_

18f. What type of respirator do you use most often?

1. Dust mask
2. Disposable N95
3. 1/2 face respirator
4. Full face respirator
5. PAPR

For questions 18g-18p, please respond for the respirator that you use most often:

18g. When you first got your respirator, were you fit tested? 1. Yes \_\_\_ 0. No \_\_\_

18h. When you use your respirator, do you do anything to check whether it fits properly? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

18i. Describe what you do to check whether your respirator fits properly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18j. Were you ever trained on the proper usage of the respirator? 1. Yes \_\_\_ 0. No \_\_\_

18k. Are respirator cartridges provided? 1. Yes \_\_\_ 0. No \_\_\_

18l. How often do you replace the respirator cartridges?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18m. Do you clean your respirator? 1. Yes \_\_\_ 0. No \_\_\_

**IF YES:**

18n. How do you clean your respirator? (*Interviewer, do not prompt by providing the options, but code responses to one or more of the following:)*

1. water alone
2. soap and water
3. alcohol wipes
4. other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18o. How often do you clean your respirator?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18p. Where do you store your respirator?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18p. Do you do anything else to maintain your respirator?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section IV. Tobacco Use Information**

**I’m now going to ask you a few questions about tobacco use.**

19a. Have you ever smoked cigarettes? 1. \_\_\_ Yes 0. \_\_\_ No

(*NO if less than 20 packs of cigarettes in a*

*lifetime or less than 1 cigarette a day for 1 year*.)

**IF YES:**

19b. How old were you when you first started

smoking regularly? \_\_\_\_\_\_ Years old

19c. Over the entire time that you have smoked,

what is the average number of cigarettes

you smoked per day? \_\_\_\_\_\_ Cigarettes/day

19d. Do you still smoke cigarettes? 1. \_\_\_ Yes 0. \_\_\_ No

**IF NO:**

19e. How old were you when you stopped

smoking cigarettes regularly? \_\_\_\_\_\_ Years old

**Thank you for participating in this survey!**

**PREGNANCY SCREENING QUESTIONS**

Low-dose HRCT will not be offered to pregnant women, due to the potential risks of radiation to the fetus. To assess pregnancy status, all female participants of menstrual age (through age 50 years) will be asked privately about pregnancy status by the study’s medical officer using the following questions:

**1. What was the first day of your last complete menstrual period?**

**Month \_\_\_\_\_ Day\_\_\_\_\_ Year\_\_\_\_\_\_\_**

**2. To the best of your knowledge, are you pregnant (or do you think you could be)?**

**Yes \_\_\_\_ No \_\_\_\_ Possibly/Not sure \_\_\_\_**

**3. If “No” to question 2, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**