

INDIUM FACILITY QUESTIONNAIRE

Today's Date: ___ / ___ / ___
(Month) (Day) (Year)

Section I: Identification and Demographic Information

Your Name: _____ (MI)
(Last name) (First name)

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: _____ (MI)
(Last name) (First name)

Contact's Relationship to you: _____

Contact's Mailing Address:

(Number, Street, and/or Rural Route)

(City) (State) (Zip Code)

Contact's Telephone Number: () _____ - _____

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing 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 this 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 NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxx).

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

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.
