Form Approved
0920-xxxx
Exp xx/xx/xxxx

CDC Water and Health Study

Instructions

An adult (18 years old or over) should fill out this survey. If there are children less than 18 in the house, the adult should fill out the survey for them.

Participation is voluntary. Return of a completed survey indicates your consent to participate. For more information, please see the enclosed brochure.

Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases

Section 1 Household Water Use

In this first section, we'd like to ask some general questions about your household water use. By "tap water," we mean drinking water supplied by your water company.

1 Please mark all of the ways that you and the people in your household have used tap water in the last 30 days. **(check all that apply)**

- ☐ Drinking
- ☐ Mixing cold drinks
- ☐ Making hot drinks
- ☐ Making ice
- ☐ Rinsing produce
- ☐ Cooking
- ☐ Mixing infant formula
- ☐ Washing dishes
- ☐ Brushing teeth
- ☐ Washing hands
- ☐ Bathing/showering
- ☐ Contact lens care
- ☐ Watering plants or lawn
- ☐ Feeding/watering animals
- ☐ Filling wading or baby pool
- ☐ Filling pool or hot tub
- ☐ Indoor or outdoor fountain
- ☐ Vaporizer or humidifier
- ☐ Nebulizer or CPAP
- ☐ Nasal/sinus irrigation or Neti pot

2 At home, what type of water do you and other members of your household drink most often? **(check only one)**

- ☐ Tap water, treated in the home (for example, boiled or filtered)
- ☐ Tap water, treated with a water softener only
- ☐ Tap water, not treated in the home
- ☐ Tap water, not sure how it is treated
- ☐ Commercially bottled water
- ☐ Other (Please specify_____)

3 Does your home have a private well?

- ☐ Yes
- ☐ No
- ☐ Don't know

4 Do you have a water softener in your home?

- ☐ Yes
- ☐ No
- ☐ Don't know

5 What water filters are used in your home? **(check all that apply)**

- ☐ No water filter used
- ☐ Water pitcher with filter
- ☐ Refrigerator dispenser with filter
- ☐ Filter on the faucet
- ☐ Filter under the sink
- ☐ Other (Please specify_____)
- ☐ Don't know

Go on to next page

Section 2 Your Home

Please answer the following general questions about your home.

6 Which of the following best describes where you live? **(check only one)**

- ☐ House
- ☐ Apartment or condominium
- ☐ Mobile Home
- ☐ Other (please specify_____)

7 What pets do you have in your home or yard? **(check all that apply)**

- ☐ No pets
- ☐ Hamster, gerbil, or mouse
- ☐ Bird
- ☐ Adult dog
- ☐ Puppy
- ☐ Reptile or amphibian (e.g. turtle, snake, iguana, frog, chameleon, salamander)
- ☐ Adult cat
- ☐ Kitten
- ☐ Other (please specify_____)

8 Are there any livestock or animal enclosures located within 50 yards of your household? **(check all that apply)**

- ☐ No livestock or animal enclosures
- ☐ Cattle or feedlots
- ☐ Poultry or poultry houses
- ☐ Pigs
- ☐ Horses
- ☐ Other livestock/animal enclosures (please specify_____)

Go on to next page

Section 3 Recent Water Service

In this section, we are asking about your recent water service. Please refer to the label on the front of this booklet or the enclosed calendar for the dates of the 3-week period.

9 At any time during the **3-week period** on the label,

- Did anyone in your home notice low water pressure? (For example, you turned on the faucet and the water didn't come out as much as usual or the pipes made a sputtering noise.)
  - ☐ Yes
  - ☐ No
  - ☐ Don't know

- Did you completely lose water service? (For example, you turned on the faucet and nothing came out.)
  - ☐ Yes
  - ☐ No
  - ☐ Don't know

- Did anyone notice a change in the odor, taste, or color of tap water at home? **(check all that apply)**
  - ☐ Change in odor
  - ☐ Change in taste
  - ☐ Change in color
  - ☐ Did not notice any changes

- Were you told to boil your water before drinking it? (For example, on the news, by a phone call, or on a door hanger)
  - ☐ Yes → If **YES**, what did you use for drinking water during that time?
    - ☐ We **only** drank bottled water.
    - ☐ We **always boiled** our tap water before we drank it.
    - ☐ We **sometimes boiled** our tap water before we drank it.
    - ☐ We usually drank our tap water **without boiling** it first.
  - ☐ No
  - ☐ Don't know

Go on to next page

Section 4 People in Your Household

10 How many people, including you, live in your household? Do not include short-term visitors.

Please enter number in box. → ☐ People

The rest of the survey asks about the individual people in your household. Please do not include short-term visitors.

To help keep the columns straight, please identify each person with initials. These do not have to be their real initials. Please keep the same order on the next pages. If there are more than 6 people in your household, please list yourself, the two oldest, and the 3 youngest. If two individuals have the same initials, different initials should be used to avoid confusion.

You may need to ask the other household members for some answers. If you cannot ask, please give your best guess.

	Person 1 (yourself)	**Person 2**	**Person 3**	**Person 4**	**Person 5**	**Person 6**
11 Person's initials	☐	☐	☐	☐	☐	☐
12 Age **(in years)** (If unsure of the exact age, please give your best guess.)	☐	☐	☐	☐	☐	☐
	Circle Male or Female					
13 Sex	Male Female	Male Female	Male Female	Male Female	Male Female	Male Female

Go on to next page

Section 5 Drinking Water Use

	Person 1 (yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
Person's initials (copy from Question 11)	☐	☐	☐	☐	☐	☐

14 What is each person's **main** source of drinking water at home?

Put an X in 1 box for each person.

Water from the tap, not filtered	☐	☐	☐	☐	☐	☐
Water from the tap, filtered	☐	☐	☐	☐	☐	☐
Bottled water	☐	☐	☐	☐	☐	☐

Other (please specify) _____

_____

In the next 2 questions, we are asking about drinking water from your water utility, or "tap water," that comes from your house. For these questions, it does not matter if you filter the water.

15 On average, about how many 8 ounce glasses of your home tap water does each person drink **per day**? Include water from home that you drink at another location, such as work, school, or sports activities.

Person 1 (yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
Glasses ☐	Glasses ☐	Glasses ☐	Glasses ☐	Glasses ☐	Glasses ☐

16 On average, about how many 8 ounce glasses of drinks mixed with your home tap water, such as Kool-Aid, instant iced tea, or watered-down juice, does each person drink **per day**? Do not include hot beverages, like brewed coffee or tea.

Person 1 (yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
Glasses ☐	Glasses ☐	Glasses ☐	Glasses ☐	Glasses ☐	Glasses ☐

Go on to next page

Section 6 Recent Activities

In this section, we are interested in recent activities you and your household members did during the 3-week period. Please refer to the label on the front of this booklet or the enclosed calendar for the dates of your 3-week period.

	Person 1 (yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
Person's initials (copy from Question 11)						

17 During the **3-week period**, did anyone

Circle Yes or No for each person.

	Person 1 (yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
● Swim or wade in a lake, river, stream or ocean?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Swim in a pool?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Swallow or drink any water directly from a spring, lake, pond, stream, or river?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Drink any water from a well?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Go hiking or camping?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Attend, work, or volunteer in a day care?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Visit a petting zoo or farm with animals?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Travel outside of the United States?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

Enter number of nights away from home.

	Person 1 (yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
● Spend any nights away from home?						

Go on to next page

Section 7 Stomach Problems

Please refer to the label on the front of this booklet or the enclosed calendar for the dates of the 3-week period. In this section, we are asking about new stomach problems that started during the 3-week period ("new onset"), not problems that you normally have.

	Person 1 (yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
Person's initials (copy from Question 11)						

18 During the **3-week period**, did anyone have a **new onset** of any of the following stomach problems?

Circle Yes or No for each person.

● Vomiting?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Nausea?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Diarrhea? (defined as 3 or more loose stools or bowel movements in any 24-hour period)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Stomach cramps?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Did they have a fever (100°F or higher) at the same time as stomach problems?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

If anyone had **ANY** stomach problems in question 18, please answer questions 19 and 20.

Write a number of days in box.

19 How many days did the stomach problems last?						
20 When did the stomach problems start? (MM/DD/YY) If you are unsure of the exact date, please give your best guess.	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__

Go on to next page

Section 8 Colds and Flu

Please refer to the label on the front of this booklet or the enclosed calendar for the dates of the 3-week period. In this section, we are asking about new cold and flu symptoms that started during the 3-week period ("new onset"), not symptoms that you normally have.

	Person 1 (yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
Person's initials (copy from Question 11)						
21 During the **3-week period**, did anyone have a **new onset** of any of the following cold/flu symptoms?	**Circle Yes or No for each person.**					
● Cough?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Runny nose?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Muscle/body aches?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Difficulty breathing?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
● Did they have a fever (100˚F or higher) at the same time as the cold or flu symptoms?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

If anyone had **ANY** cold/flu symptoms in question 21, please answer questions 22 and 23.

	Write a number of days in box.					
22 How many days did the cold/flu symptoms last?						
23 When did the cold/flu symptoms start? (MM/DD/YY) If you are unsure of the exact date, please give your best guess.	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__

If you answered Yes to **any** stomach problems or cold or flu symptoms in **section 7 or section 8**, please go on to **section 9**, Illness Details on the next page. If no one in your household had any stomach problems, cold or flu symptoms please skip to **section 10**.

Section 9 Illness Details

Please complete the section **only** if you answered Yes to **any** symptoms in **section 7 or section 8**. If no one had stomach problems, cold or flu symptoms in the 3-week period, you can skip to **section 10** on the next page.

These questions are asking about how illnesses during the 3-week period affected you.

	Person 1 (yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
Person's initials (copy from Question 11)	☐	☐	☐	☐	☐	☐
	Write a number of days in box.					
24 How many days of school or work did each person miss because of stomach problems, cold or flu? **(enter number of days missed, enter 0 if no school or work missed)**	☐	☐	☐	☐	☐	☐
	Circle Yes or No for each person.					
25 Did anyone see a healthcare provider **for stomach problems, cold, or flu symptoms**?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
26 Did a healthcare provider ask anyone to submit a stool sample for testing?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
27 Was anyone **admitted** to the hospital for at least one day as a result of this illness?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

Go on to next page

Section 10 More About People in Your Household

	Person 1 (yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
Person's initials (copy from Question 11)						
	Circle Yes or No for each person.					
28 Does any household member have chronic diarrhea or vomiting (because of a health condition like Irritable Bowel Syndrome, Crohn's disease, Ulcerative colitis, etc. or a medication side effect?)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
29 Does any household member have a chronic respiratory condition (such as asthma, emphysema, COPD, etc.)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

Section 11 Demographic Information

The following questions are optional, but providing answers will help us better understand how well our study is describing the experience in your community.

	Person 1 (yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
30 Is each person of Hispanic or Latino ethnicity? **(Please answer for yourself and Persons 2-6)**	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
31 What is each person's race? Mark one or more boxes. **(Please answer for yourself and Persons 2-6)**	**Check all that apply.**					
American Indian or Alaska Native						
Asian						
Black or African American						
Native Hawaiian or other Pacific Islander						
White						

Comments

Are there any additional comments or information that you would like to provide?

This concludes the CDC Water and Health Study. Thank you!

We really appreciate your participation in this important study. Please fold this survey in half lengthwise, place it in the enclosed postage-paid envelope and put it in any U.S. Mail box.

Please mail to:

CDC
Mailstop C-09
Attention: Water and Health Study
1600 Clifton Rd. NE
Atlanta, GA 30333

Fold along dotted line and place in envelope.