Appendix D: School Health Questionnaire

Form Approved
OMB No. 0920-XXXX
Expires

Dear School District Employee,

The National Institute for Occupational Safety and Health (NIOSH) would like to thank you for participating in this health questionnaire survey. The purpose of this survey is to collect data that may be useful for studying the association between health symptoms and damp conditions in 50 selected elementary schools.

The questionnaire should take a maximum of 20 minutes to complete, and you can stop at any point if necessary. Completed sections would be saved until you were able to return and complete the questionnaire.

CONSENT:

Your participation is voluntary. You may choose to be in the study or not. You can choose to answer any or all of the questions. You may drop out any time, for any reason, without consequences to you. NIOSH is authorized to collect your personal information and will protect it to the extent allowed by law. There are conditions under the Privacy Act where your information may be released to collaborators or contractors, health departments or disease registries, to the Departments of Justice or Labor, or to Congressional offices. Any risks from completing this survey are minimal. The only risk we anticipate is the potential for loss of confidentiality. To minimize this risk all data is stored on a secure server at the Centers for Disease Control and Prevention, and only those authorized to work on this study will be able to see your results. For questions about your rights, your privacy, or harm to you, contact the Director of Human Research Protections, Mark Toraason at mtoraason@cdc.gov, or 513-533-8591. There are no direct benefits to you personally for participating in the study. However, what we learn may reduce health symptoms in school employees by providing proper approaches for responding to dampness in school buildings.

By completing the questionnaire, you give your consent to participate.

Public reporting burden of this collection of information is estimated to average 20 minutes or less 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

Demographics:

1. Date of Birth: __ __ / __ __ / __ __ __ __
Month Day Year

2. Gender: ____ Male
____ Female

3. Ethnicity (Please choose one):
____ Hispanic or Latino
____ Not Hispanic or Latino

4. Race (Please choose all that apply):
____ American Indian or Alaska Native
____ Asian
____ Black or African American
____ Native Hawaiian or Other Pacific Islander
____ White

Employment History:

5. What is the date you first started work in this school system? __ __ /__ __ __ __
Mo Yr

6. Please indicate your current job title:

_____Teacher
Grade taught (drop down)
_____Teacher's Aide/Assistant
Grade taught (drop down)
_____School Administration
_____Office Staff
_____School Engineer
_____Maintenance
_____Custodian/Janitorial/Cleaning
_____Medical Staff
_____Library Staff
_____Counselor
_____Security
_____Cafeteria/Kitchen Worker
_____Other (*specify*_____________)

7. How many schools have you worked at in this school district in the past 12 months? _____
(Number generates loop number)

1) School Name (drop down)
Currently working at school? ___Yes ___No
Date started: __ __ /__ __ __ __
Mo Yr
Date ended: __ __ /__ __ __ __ or current
Mo Yr

Please list all rooms in this school in which you spend/spent four or more hours a week. For each room listed, please also indicate the total number of hours per week.

Room name/Room number	Hours per Week

2) School Name (drop down)
Currently working at school? ___Yes ___No
Date started: __ __ /__ __ __ __
Mo Yr
Date ended: __ __ /__ __ __ __ or current
Mo Yr

Please list all rooms in this school in which you spend/spent four or more hours a week. For each room listed, please also indicate the total number of hours per week.

Rooms Spent Most Time in	Hours per Week

3) School Name (drop down)
Currently working at school? ___Yes ___No
Date started: __ __ /__ __ __ __
Mo Yr
Date ended: __ __ /__ __ __ __ or current
Mo Yr

Please list all rooms in this school in which you spend/spent four or more hours a week. For each room listed, please also indicate the total number of hours per week.

Rooms Spent Most Time in	Hours per Week

Health Symptoms

The following questions are about your health. If you don't know whether to answer yes or no to a particular question, please answer no.

4.1 During the past 12 months have you had wheezing or whistling in your chest at any time? ___Yes ___No

IF YES:

4.2 When you were away from school on weekends, days off, or vacations, is the wheezing or whistling: ___Same ___Worse ___Better

4.3 Have you had wheezing or whistling in your chest in the last 4 weeks? ___Yes ___No

IF YES:
4.3.1 Have you had wheezing or whistling in your chest one or more times per week in the last 4 weeks? ___Yes ___No

5.1 During the past 12 months have you had chest tightness? ___Yes ___No

IF YES:

5.2 When you were away from school on weekends, days off, or vacations, is the chest tightness: ___Same ___Worse ___Better

5.3 Have you had chest tightness in the last 4 weeks? ___Yes ___No

IF YES:
5.3.1 Have you had chest tightness one or more times per week in the last 4 weeks? ___Yes ___No

6.1 During the past 12 months have you had attacks of shortness of breath? ___Yes ___No

IF YES:

6.2 When you were away from school on weekends, days off, or vacations, are the attacks of shortness of breath: ___Same ___Worse ___Better

6.3 Have you had attacks of shortness of breath in the last 4 weeks? ___Yes ___No

IF YES:
6.3.1 Have you had attacks of shortness of breath one or more times per week in the last 4 weeks? ___Yes ___No

7.1 During the past 12 months have you had attacks of cough? ___Yes ___No

IF YES:

7.2 When you were away from school on weekends, days off, or vacations, are the attacks of cough: ___Same ___Worse ___Better

7.3 Have you had attacks of cough in the last 4 weeks? ___Yes ___No

IF YES:
7.3.1 Have you had attacks of cough one or more times per week in the last 4 weeks? ___Yes ___No

8.1 During the past 12 months have you been awakened by an attack of breathing difficulty? ___Yes ___No

IF YES:

8.2 When you were away from school on weekends, days off, or vacations, is the awakening by attacks of breathing difficulty: ___Same ___Worse ___Better

8.3 Have you been awakened by an attack of breathing difficulty in the last 4 weeks? ___Yes ___No

IF YES:
8.3.1 Have you been awakened by an attack of breathing difficulty one or more times per week in the last 4 weeks? ___Yes ___No

9.1 During the past 12 months, have you had shortness of breath walking with people of your own age on level ground? ___Yes ___No

IF YES:

9.2 When you were away from school on weekends, days off, or vacations, is this shortness of breath: ___Same ___Worse ___Better

9.3 Have you had shortness of breath walking with people of your own age on level ground in the past 4 weeks? ___Yes ___No

IF YES:
9.3.1 Have you had shortness of breath walking with people of your own age on level ground one or more times per week in the past 4 weeks? ___Yes ___No

10.1 During the past 12 months have you had any episodes of stuffy, itchy ___Yes ___No

or runny nose?

IF YES:

10.2 When you were away from school on weekends, days off, or vacations, is the stuffy, itchy or runny nose: ___Same ___Worse ___Better

10.3 Have you had a stuffy, itchy or runny nose in the last 4 weeks? ___Yes ___No

IF YES:
10.3.1 Have you had a stuffy, itchy or runny nose one or more times per week in the last 4 weeks? ___Yes ___No

11.1 During the past 12 months have you had sinusitis or sinus problems? ___Yes ___No

IF YES:

11.2 When you were away from school on weekends, days off, or vacations, are the sinusitis or sinus problems: ___Same ___Worse ___Better

11.3 Have you had sinusitis or sinus problems in the last 4 weeks? ___Yes ___No

IF YES:
11.3.1 Have you had sinusitis or sinus problems one or more times per week in the last 4 weeks? ___Yes ___No

12.1 During the past 12 months have you had a sore or dry throat? ___Yes ___No

IF YES:

12.2 When you are away from school on weekends, days off, or vacations, is the sore or dry throat: ___Same ___Worse ___Better

12.3 Have you had a sore or dry throat in the last 4 weeks? ___Yes ___No

IF YES:
12.3.1 Have you had a sore or dry throat one or more times per week in the last 4 weeks? ___Yes ___No

13.1 During the past 12 months have you had dry or itchy skin? ___Yes ___No

IF YES:

13.2 When you were away from school on weekends, days off, or vacations, is the dry or itchy skin:
___Same ___Worse ___Better

13.3 Have you had dry or itchy skin in the last 4 weeks? ___Yes ___No

IF YES:
13.3.1 Have you had dry or itchy skin one or more times per week in the last 4 weeks? ___Yes ___No

14.1 During the past 12 months have you had any episodes of watery, itchy eyes? ___Yes ___No

IF YES:

14.2 When you are away from school on weekends, days off, or vacations, are the watery or itchy eyes:
___Same ___Worse ___Better

14.3 Have you had watery or itchy eyes in the last 4 weeks? ___Yes ___No

IF YES:
14.3.1 Have you had watery or itchy eyes one or more times per week in the last 4 weeks? ___Yes ___No

15.1 During the past 12 months have you had episodes of fever and chills? ___Yes ___No

IF YES:

15.2 When you were away from school on weekends, days off, or vacations, are these episodes of fever and chills ___Same ___Worse ___Better

15.3 Have you had episodes of fever and chills in the last 4 weeks? ___Yes ___No
last 4 weeks?

IF YES:
15.3.1 Have you had episodes of fever and chills one or more times per week in the last 4 weeks? ___Yes ___No

16.1 During the past 12 months have you had episodes of flu-like achiness ___Yes ___No

or achy joints?

IF YES:

16.2 When you were away from school on weekends, days off, or vacations, is the flu-like achiness or achy joints: ___Same ___Worse ___Better

16.3 Have you had episodes of flu-like achiness or achy joints in the last 4 weeks? ___Yes ___No

IF YES:

16.3.1 Have you had episodes of flu-like achiness or achy joints one or more times per week in the last 4 weeks? ___Yes ___No

17.1 During the past 12 months have you had unusual tiredness or fatigue? ___Yes ___No

IF YES:

17.2 When you were away from school on weekends, days off, or vacations, is the unusual tiredness or fatigue: ___Same ___Worse ___Better

17.3 Have you had unusual tiredness or fatigue in the last 4 weeks? ___Yes ___No

IF YES:

17.3.1 Have you had unusual tiredness or fatigue one or more times per week in the last 4 weeks? ___Yes ___No

18.1 During the past 12 months have you had difficulty remembering things? ___Yes ___No

IF YES:

18.2 When you were away from school on weekends, days off, or vacations, is the difficulty remembering things: ___Same ___Worse ___Better

18.3 Have you had difficulty remembering things in the last 4 weeks? ___Yes ___No

IF YES:

18.3.1 Have you had difficulty remembering things one or more times per week in the last 4 weeks? ___Yes ___No

19.1 During the past 12 months have you had difficulty concentrating? ___Yes ___No

IF YES:

19.2 When you were away from school on weekends, days off, or vacations, is the difficulty concentrating: ___Same ___Worse ___Better

19.3 Have you had difficulty concentrating in the last 4 weeks? ___Yes ___No

IF YES:
19.3.1 Have you had difficulty concentrating one or more times per week in the last 4 weeks? ___Yes ___No

20.1 During the past 12 months have you had confusion or disorientation? ___Yes ___No
IF YES:

20.2 When you were away from school on weekends, days off, or vacations, is the confusion or disorientation: ___Same ___Worse ___Better

20.3 Have you had confusion or disorientation in the last 4 weeks? ___Yes ___No

IF YES:
20.3.1 Have you had confusion or disorientation one or more times per week in the last 4 weeks? ___Yes ___No

21.1 During the past 12 months have you had dizziness or lightheadedness? ___Yes ___No
IF YES:

21.2 When you were away from school on weekends, days off, or vacations, is the dizziness or lightheadedness: ___Same ___Worse ___Better

21.3 Have you had dizziness or lightheadedness in the last 4 weeks? ___Yes ___No

IF YES:
21.3.1 Have you had dizziness or lightheadedness one or more times per week in the last 4 weeks? ___Yes ___No

22.1 During the past 12 months have you had headaches? ___Yes ___No
IF YES:

22.2 When you were away from school on weekends, days off, or vacations, are the headaches: ___Same ___Worse ___Better

22.3 Have you had headaches in the last 4 weeks? ___Yes ___No

IF YES:
22.3.1 Have you had headaches one or more times per week in the last 4 weeks? ___Yes ___No

Infections

23.1 During the past 12 months have you had an influenza-like illness (an episode of fever and cough that came on rapidly, lasted for one or more days, and may have also included fatigue, muscle aches, or sore throat)? ___Yes ___No

IF YES:

23.2 Have you had an influenza-like illness in the last 4 weeks? ___Yes ___No

24.1 In the past 12 months have you had pneumonia? ___Yes ___No

IF YES:

24.2 Have you had pneumonia in the last 4 weeks? ___Yes ___No

25.1 In the past 12 months have you had acute bronchitis? ___Yes ___No

IF YES:

25.2 Have you had acute bronchitis in the last 4 weeks? ___Yes ___No

26.1 During the past 12 months have you had a sudden onset of nausea, vomiting, or diarrhea for one or more days? ___Yes ___No

IF YES:

26.2 Have you had a sudden onset of nausea, vomiting, or diarrhea that lasted for one or more days in the last 4 weeks? ___Yes ___No

27. During the past 12 months have you had an upper respiratory infection which has involved the…

CONDITION	Yes	No
27.1 Nose?		
27.2 Sinuses?		
27.3 Throat?		
27.4 Ears?		
27.5 Common cold?		

Medical Conditions

28.1 Has a doctor or other health professional ever told you that you have asthma? ___Yes ___No

IF YES:

28.2 In what month and year were you first diagnosed with asthma? __ __ / __ __ __ __
Month Year

28.3 Do you still have asthma? ___Yes ___No

29.1 Has a doctor or other health professional ever told you that you ___Yes ___No

have hypersensitivity pneumonitis?

IF YES:

29.2 In what month and year were you first diagnosed with hypersensitivity pneumonitis? __ __ / __ __ __ __ Month Year

30.1 Has a doctor or other health professional ever told you that you have sarcoidosis? ___Yes ___No

IF YES:

30.2 In what month and year were you first diagnosed with sarcoidosis? __ __ / __ __ __ __ Month Year

31. Has a doctor or other health professional ever told you that you have…

CONDITION	Yes	No
31.1 Nasal or sinus allergies, including hay fever?		
31.2 Eczema or any kind of skin allergy?		
31.3 Allergies to animals?		
31.4 Allergies to dust or dust mites?		
31.5 Chronic bronchitis?		
31.6 Emphysema?		
31.7 Heart disease?		
31.8 Chronic Obstructive Pulmonary Disease (COPD)?		

32.1 Has a doctor or other health professional ever told you that you have any other respiratory condition? ___Yes ___No

IF YES:

32.2 Name of respiratory condition: ____

32.3 In what month and year were you first diagnosed with this condition? __ __ / __ __ __ __ Month Year

32.4 Do you still have this condition? ___Yes ___No

Work Days Missed Due to Health Problems

33.1 In the past 12 months, how many days have you missed work because of respiratory health problems? ________ Days

34.1 In the past 12 months, how many days have you missed work ________ Days

because of health problems other than respiratory?

Home Environment

35.1 During the past 12 months, have you observed water leakage or water damage indoors on walls, floors, or ceiling in your house or apartment? ___Yes ___No

IF YES:

35.2 Have you observed water leakage or water damage indoors in the last 4 weeks in your house or apartment? ___Yes ___No

36.1 During the past 12 months, have you observed visible mold growth (not on food) indoors on walls, floors, or ceilings? ___Yes ___No

IF YES:

36.2 Have you observed visible mold growth indoors on walls, floors, or ceilings in your house or apartment? ___Yes ___No

37.1 During the past 12 months, have you observed an odor of mold or mildew (not from food) in your house or apartment? ___Yes ___No

IF YES:

37.2 Have you observed an odor of mold or mildew in the last 4 weeks in your house or apartment? ___Yes ___No

Smoking History

38.1 Have you ever smoked cigarettes regularly? ___Yes ___No
(Please mark "No" if you have smoked less than 100 cigarettes in your lifetime.)

IF YES:

38.2 Do you still smoke cigarettes? ___Yes ___No

General Comments

39.1 Do you have any other additional comments or concerns? ___Yes ___No

IF YES:

39.2 Please describe:
____
____
____

Thank you for your time in completing this survey.