**Appendix D: School Health Questionnaire**

Form Approved

OMB No. 0920-1047

Expires 1/31/2016

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 (0920-1047).

## 

## 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

5. Please indicate the zip code of your current residence: \_\_ \_\_ \_\_ \_\_ \_\_

**Employment History:**

6. What is the date you first started work in this school system? \_\_ \_\_ /\_\_ \_\_ \_\_ \_\_

Mo Yr

7. 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*\_\_\_\_\_\_\_\_\_\_\_\_\_)

8. 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 |
|  |  |
|  |  |
|  |  |

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.*

|  |  |
| --- | --- |
| Rooms Spent Most Time in | Hours per Week |
|  |  |
|  |  |
|  |  |

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.*

|  |  |
| --- | --- |
| 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.*

9.1 During the past 12 months have you had wheezing or whistling in your chest \_\_\_Yes \_\_\_No

at any time?

IF YES:

9.2 When you were away from school on weekends, days off, or vacations, is the wheezing or whistling:

\_\_\_Same \_\_\_Worse \_\_\_Better

9.3 Have you had wheezing or whistling in your chest in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

9.3.1 Have you had wheezing or whistling in your chest one or more times per \_\_\_Yes \_\_\_No

week in the last 4 weeks?

10.1 During the past 12 months have you had chest tightness? \_\_\_Yes \_\_\_No

IF YES:

10.2 When you were away from school on weekends, days off, or vacations, is the chest tightness:

\_\_\_Same \_\_\_Worse \_\_\_Better

10.3 Have you had chest tightness in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

10.3.1 Have you had chest tightness one or more times per week in the last \_\_\_Yes \_\_\_No

4 weeks?

11.1 During the past 12 months have you had attacks of shortness of breath? \_\_\_Yes \_\_\_No

IF YES:

11.2 When you were away from school on weekends, days off, or vacations, are the attacks of shortness of breath: \_\_\_Same \_\_\_Worse \_\_\_Better

11.3 Have you had attacks of shortness of breath in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

11.3.1 Have you had attacks of shortness of breath one or more times per week \_\_\_Yes \_\_\_No

in the last 4 weeks?

12.1 During the past 12 months have you had attacks of cough? \_\_\_Yes \_\_\_No

IF YES:

12.2 When you were away from school on weekends, days off, or vacations, are the attacks of cough:

\_\_\_Same \_\_\_Worse \_\_\_Better

12.3 Have you had attacks of cough in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

12.3.1 Have you had attacks of cough one or more times per week in the last \_\_\_Yes \_\_\_No

4 weeks?

13.1 During the past 12 months have you been awakened by an attack of breathing \_\_\_Yes \_\_\_No

difficulty?

IF YES:

13.2 When you were away from school on weekends, days off, or vacations, is the awakening by attacks of

breathing difficulty: \_\_\_Same \_\_\_Worse \_\_\_Better

13.3 Have you been awakened by an attack of breathing difficulty in the last \_\_\_Yes \_\_\_No

4 weeks?

IF YES:

13.3.1 Have you been awakened by an attack of breathing difficulty one or more \_\_\_Yes \_\_\_No

times per week in the last 4 weeks?

14.1 During the past 12 months, have you had shortness of breath walking with \_\_\_Yes \_\_\_No people of your own age on level ground?

IF YES:

14.2 When you were away from school on weekends, days off, or vacations, is this shortness of breath: \_\_\_Same \_\_\_Worse \_\_\_Better

14.3 Have you had shortness of breath walking with people of your own age on \_\_\_Yes \_\_\_No

level ground in the past 4 weeks?

IF YES:

14.3.1 Have you had shortness of breath walking with people of your own \_\_\_Yes \_\_\_No

age on level ground one or more times per week in the past 4 weeks?

15.1 During the past 12 months have you had any episodes of stuffy, itchy \_\_\_Yes \_\_\_No

or runny nose?

IF YES:

15.2 When you were away from school on weekends, days off, or vacations, is the stuffy, itchy or runny nose: \_\_\_Same \_\_\_Worse \_\_\_Better

15.3 Have you had a stuffy, itchy or runny nose in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

15.3.1 Have you had a stuffy, itchy or runny nose one or more times \_\_\_Yes \_\_\_No

per week in the last 4 weeks?

16.1 During the past 12 months have you had sinusitis or sinus problems? \_\_\_Yes \_\_\_No

IF YES:

16.2 When you were away from school on weekends, days off, or vacations, are the sinusitis or sinus problems: \_\_\_Same \_\_\_Worse \_\_\_Better

16.3 Have you had sinusitis or sinus problems in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

16.3.1 Have you had sinusitis or sinus problems one or more times per \_\_\_Yes \_\_\_No

week in the last 4 weeks?

17.1 During the past 12 months have you had a sore or dry throat? \_\_\_Yes \_\_\_No

IF YES:

17.2 When you are away from school on weekends, days off, or vacations, is the sore or dry throat:

\_\_\_Same \_\_\_Worse \_\_\_Better

17.3 Have you had a sore or dry throat in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

17.3.1 Have you had a sore or dry throat one or more times per week in \_\_\_Yes \_\_\_No

the last 4 weeks?

18.1 During the past 12 months have you had dry or itchy skin? \_\_\_Yes \_\_\_No

IF YES:

18.2 When you were away from school on weekends, days off, or vacations, is the dry or itchy skin:

\_\_\_Same \_\_\_Worse \_\_\_Better

18.3 Have you had dry or itchy skin in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

18.3.1 Have you had dry or itchy skin one or more times per week \_\_\_Yes \_\_\_No

in the last 4 weeks?

19.1 During the past 12 months have you had any episodes of watery, itchy eyes? \_\_\_Yes \_\_\_No

IF YES:

19.2 When you are away from school on weekends, days off, or vacations, are the watery or itchy eyes: \_\_\_Same \_\_\_Worse \_\_\_Better

19.3 Have you had watery or itchy eyes in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

19.3.1 Have you had watery or itchy eyes one or more times per week \_\_\_Yes \_\_\_No

in the last 4 weeks?

20.1 During the past 12 months have you had episodes of fever and chills? \_\_\_Yes \_\_\_No

IF YES:

20.2 When you were away from school on weekends, days off, or vacations, are these episodes of fever and chills \_\_\_Same \_\_\_Worse \_\_\_Better

20.3 Have you had episodes of fever and chills in the last 4 weeks? \_\_\_Yes \_\_\_No

last 4 weeks?

IF YES:

20.3.1 Have you had episodes of fever and chills one or more times \_\_\_Yes \_\_\_No

per week in the last 4 weeks?

21.1 During the past 12 months have you had episodes of flu-like achiness \_\_\_Yes \_\_\_No

or achy joints?

IF YES:

21.2 When you were away from school on weekends, days off, or vacations, is the

flu-like achiness or achy joints: \_\_\_Same \_\_\_Worse \_\_\_Better

21.3 Have you had episodes of flu-like achiness or achy joints in the \_\_\_Yes \_\_\_No

last 4 weeks?

IF YES:

21.3.1 Have you had episodes of flu-like achiness or achy joints \_\_\_Yes \_\_\_No

one or more times per week in the last 4 weeks?

22.1 During the past 12 months have you had unusual tiredness or fatigue? \_\_\_Yes \_\_\_No

IF YES:

22.2 When you were away from school on weekends, days off, or vacations, is the unusual tiredness

or fatigue: \_\_\_Same \_\_\_Worse \_\_\_Better

22.3 Have you had unusual tiredness or fatigue in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

22.3.1 Have you had unusual tiredness or fatigue one or more times \_\_\_Yes \_\_\_No

per week in the last 4 weeks?

23.1 During the past 12 months have you had difficulty remembering things? \_\_\_Yes \_\_\_No

IF YES:

23.2 When you were away from school on weekends, days off, or vacations, is the difficulty

remembering things: \_\_\_Same \_\_\_Worse \_\_\_Better

23.3 Have you had difficulty remembering things in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

23.3.1 Have you had difficulty remembering things one or more times \_\_\_Yes \_\_\_No

per week in the last 4 weeks?

24.1 During the past 12 months have you had difficulty concentrating? \_\_\_Yes \_\_\_No

IF YES:

24.2 When you were away from school on weekends, days off, or vacations, is the difficulty concentrating: \_\_\_Same \_\_\_Worse \_\_\_Better

24.3 Have you had difficulty concentrating in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

24.3.1 Have you had difficulty concentrating one or more times per \_\_\_Yes \_\_\_No

week in the last 4 weeks?

25.1 During the past 12 months have you had confusion or disorientation? \_\_\_Yes \_\_\_No IF YES:

25.2 When you were away from school on weekends, days off, or vacations, is the confusion or disorientation: \_\_\_Same \_\_\_Worse \_\_\_Better

25.3 Have you had confusion or disorientation in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

25.3.1 Have you had confusion or disorientation one or more times per \_\_\_Yes \_\_\_No

week in the last 4 weeks?

26.1 During the past 12 months have you had dizziness or lightheadedness? \_\_\_Yes \_\_\_No

IF YES:

26.2 When you were away from school on weekends, days off, or vacations, is the dizziness or lightheadedness: \_\_\_Same \_\_\_Worse \_\_\_Better

26.3 Have you had dizziness or lightheadedness in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

26.3.1 Have you had dizziness or lightheadedness one or more times \_\_\_Yes \_\_\_No

per week in the last 4 weeks?

27.1 During the past 12 months have you had headaches? \_\_\_Yes \_\_\_No

IF YES:

27.2 When you were away from school on weekends, days off, or vacations,

are the headaches: \_\_\_Same \_\_\_Worse \_\_\_Better

27.3 Have you had headaches in the last 4 weeks? \_\_\_Yes \_\_\_No

IF YES:

27.3.1 Have you had headaches one or more times per week in the last 4 weeks? \_\_\_Yes \_\_\_No

**Infections**

28.1 During the past 12 months have you had an influenza-like illness (an episode \_\_\_Yes \_\_\_No

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)?

IF YES:

28.2 Have you had an influenza-like illness in the last 4 weeks? \_\_\_Yes \_\_\_No

29.1 In the past 12 months have you had pneumonia? \_\_\_Yes \_\_\_No

IF YES:

29.2 Have you had pneumonia in the last 4 weeks? \_\_\_Yes \_\_\_No

30.1 In the past 12 months have you had acute bronchitis? \_\_\_Yes \_\_\_No

IF YES:

30.2 Have you had acute bronchitis in the last 4 weeks? \_\_\_Yes \_\_\_No

31.1 During the past 12 months have you had a sudden onset of nausea, vomiting, \_\_\_Yes \_\_\_No

or diarrhea for one or more days?

IF YES:

31.2 Have you had a sudden onset of nausea, vomiting, or diarrhea that lasted \_\_\_Yes \_\_\_No

for one or more days in the last 4 weeks?

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

|  |  |  |
| --- | --- | --- |
| CONDITION | Yes | No |
| 32.1 Nose? |  |  |
| 32.2 Sinuses? |  |  |
| 32.3 Throat? |  |  |
| 32.4 Ears? |  |  |
| 32.5 Common cold? |  |  |

**Medical Conditions**

33.1 Has a doctor or other health professional ever told you that you \_\_\_Yes \_\_\_No

have asthma?

IF YES:

33.2 In what month and year were you first diagnosed with asthma? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

Month Year

33.3 Do you still have asthma? \_\_\_Yes \_\_\_No

34.1 Has a doctor or other health professional ever told you that you \_\_\_Yes \_\_\_No

have hypersensitivity pneumonitis?

IF YES:

34.2 In what month and year were you first diagnosed with \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

hypersensitivity pneumonitis? Month Year

35.1 Has a doctor or other health professional ever told you that you \_\_\_Yes \_\_\_No

have sarcoidosis?

IF YES:

35.2 In what month and year were you first diagnosed with sarcoidosis? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

Month Year

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

|  |  |  |
| --- | --- | --- |
| CONDITION | Yes | No |
| 36.1 Nasal or sinus allergies, including hay fever? |  |  |
| 36.2 Eczema or any kind of skin allergy? |  |  |
| 36.3 Allergies to animals? |  |  |
| 36.4 Allergies to dust or dust mites? |  |  |
| 36.5 Chronic bronchitis? |  |  |
| 36.6 Emphysema? |  |  |
| 36.7 Heart disease? |  |  |
| 36.8 Chronic Obstructive Pulmonary Disease (COPD)? |  |  |

37.1 Has a doctor or other health professional ever told you that you \_\_\_Yes \_\_\_No

have any other respiratory condition?

IF YES:

37.2 Name of respiratory condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

37.3 In what month and year were you first diagnosed with this condition? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

Month Year

37.4 Do you still have this condition? \_\_\_Yes \_\_\_No

**Work Days Missed Due to Health Problems**

38.1 In the past 12 months, how many days have you missed work \_\_\_\_\_\_\_ Days

because of respiratory health problems?

38.1 In the past 12 months, how many days have you missed work \_\_\_\_\_\_\_ Days

because of health problems other than respiratory?

### Home Environment

39.1 During the past 12 months, have you observed water leakage or water \_\_\_Yes \_\_\_No

damage indoors on walls, floors, or ceiling in your house or apartment?

IF YES:

39.2 Have you observed water leakage or water damage indoors in the \_\_\_Yes \_\_\_No

last 4 weeks in your house or apartment?

40.1 During the past 12 months, have you observed visible mold growth (not \_\_\_Yes \_\_\_No

on food) indoors on walls, floors, or ceilings?

IF YES:

40.2 Have you observed visible mold growth indoors on walls, floors, \_\_\_Yes \_\_\_No

or ceilings in your house or apartment?

41.1 During the past 12 months, have you observed an odor of mold or \_\_\_Yes \_\_\_No

mildew (not from food) in your house or apartment?

IF YES:

41.2 Have you observed an odor of mold or mildew in the last 4 weeks in \_\_\_Yes \_\_\_No

your house or apartment?

**Smoking History**

42.1 Have you ever smoked cigarettes regularly? \_\_\_Yes \_\_\_No

*(Please mark “No” if you have smoked less than 100 cigarettes in your lifetime.)*

IF YES:

42.2 Do you still smoke cigarettes? \_\_\_Yes \_\_\_No

**General Comments**

43.1 Do you have any other additional comments or concerns? \_\_\_Yes \_\_\_No

IF YES:

43.2 Please describe:

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

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

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

**Thank you for your time in completing this survey.**