

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

- 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.

9.1 During the past 12 months have you had wheezing or whistling in your chest at any time? Yes No

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 week in the last 4 weeks? Yes No

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 4 weeks? Yes No

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 in the last 4 weeks? Yes No

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 4 weeks? Yes No

13.1 During the past 12 months have you been awakened by an attack of breathing difficulty? Yes No

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 4 weeks? Yes No

IF YES:

13.3.1 Have you been awakened by an attack of breathing difficulty one or more times per week in the last 4 weeks? Yes No

14.1 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:

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 level ground in the past 4 weeks? Yes No

IF YES:

14.3.1 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

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 per week in the last 4 weeks? Yes No

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 week in the last 4 weeks? Yes No

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 the last 4 weeks? Yes No

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 in the last 4 weeks? Yes No

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 in the last 4 weeks? Yes No

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

IF YES:

20.3.1 Have you had episodes of fever and chills one or more times per week in the last 4 weeks? Yes No

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 last 4 weeks? Yes No

IF YES:

21.3.1 Have you had episodes of flu-like achiness or achy joints one or more times per week in the last 4 weeks? Yes No

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 per week in the last 4 weeks? Yes No

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 per week in the last 4 weeks? Yes No

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 week in the last 4 weeks? Yes No

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 week in the last 4 weeks? Yes No

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 per week in the last 4 weeks? Yes No

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 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:

28.2	Have you had an influenza-like illness in the last 4 weeks?	___ Yes ___ No
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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
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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
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31.1 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:

31.2	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
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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 have asthma? ___ Yes ___ No

IF YES:

33.2	In what month and year were you first diagnosed with asthma?	___ ___ / ___ ___ ___ Month Year
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33.3	Do you still have asthma?	___ Yes ___ No
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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 have sarcoidosis? ___Yes ___No

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 have any other respiratory condition? ___Yes ___No

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 because of respiratory health problems? _____ Days

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 damage indoors on walls, floors, or ceiling in your house or apartment? Yes No

IF YES:

39.2 Have you observed water leakage or water damage indoors in the last 4 weeks in your house or apartment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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40.1 During the past 12 months, have you observed visible mold growth (not on food) indoors on walls, floors, or ceilings? Yes No

IF YES:

40.2 Have you observed visible mold growth indoors on walls, floors, or ceilings in your house or apartment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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41.1 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:

41.2 Have you observed an odor of mold or mildew in the last 4 weeks in your house or apartment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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.