

Form Approved
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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

Public reporting burden of this collection of information is estimated to average 12 minutes 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0960).

SECTION 1 HOUSEHOLD WATER USE

In this first section, we'd like to ask some general questions about your household water use. 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.

- 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)**
- | | |
|--|---|
| <input type="checkbox"/> Drinking | <input type="checkbox"/> Feeding/watering animals |
| <input type="checkbox"/> Mixing cold drinks | <input type="checkbox"/> Filling wading or baby pool |
| <input type="checkbox"/> Making hot drinks | <input type="checkbox"/> Filling swimming pool or hot tub |
| <input type="checkbox"/> Mixing infant formula | <input type="checkbox"/> Indoor or outdoor fountain |
| <input type="checkbox"/> Making ice | <input type="checkbox"/> Vaporizer or humidifier |
| <input type="checkbox"/> Rinsing produce | <input type="checkbox"/> Nebulizer or CPAP |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Nasal/sinus irrigation or Neti pot |
| <input type="checkbox"/> Washing dishes | |
| <input type="checkbox"/> Brushing teeth | |
| <input type="checkbox"/> Washing hands | |
| <input type="checkbox"/> Bathing/showering | |
| <input type="checkbox"/> Contact lens care | |
| <input type="checkbox"/> Watering plants or lawn | |
- 2** At home, does anyone use hot water directly from the tap to make drinks or prepare instant foods?
- Yes
 No
 Don't know
- 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
 Whole house filter
 Other (please specify _____)
 Don't know

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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
 - Townhouse or duplex
 - Mobile home
 - Other (please specify _____)
- 7** What pets do you have in your home or yard? **(check all that apply)**
- No pets
 - Adult dog
 - Puppy
 - Adult cat
 - Kitten
 - Hamster, gerbil, or mouse
 - Bird
 - Reptile or amphibian (for example, turtle, snake, iguana, frog, chameleon, salamander)
 - Fish
 - Other (please specify _____)
- 8** Are there any livestock located within 50 yards of your household? **(check all that apply)**
- No livestock
 - Cattle
 - Poultry
 - Pigs
 - Goats
 - Sheep
 - Horses
 - Other livestock (please specify _____)

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 2-week period.

9 At any time during the **2-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
- Was any work done on the water pipes near your home?
 - 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
 - No
 - Don't know

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.

SECTION 4 PEOPLE IN YOUR HOUSEHOLD

10 How many people, including you, live in your household?

Please enter number in box.  People

The rest of the survey asks about the individual people in your household.

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 2 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 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 12 Age (in years) (If unsure of the exact age, please give your best guess.) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 13 Sex | Circle Male or Female. Male Female | Male Female | Male Female | Male Female | Male Female | Male Female |

SECTION 5 DRINKING WATER USE

On this page, we are asking about drinking water from your water utility, or “tap water,” that comes from your house, as well as other kinds of water you drink.

| | Person 1 (yourself) | Person 2 | Person 3 | Person 4 | Person 5 | Person 6 |
|--|------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Person’s initials (copy from Question 11) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

14 At home, which kinds of water does each person usually drink? **Circle yes or no for each kind of water.**

| | Person 1 | Person 2 | Person 3 | Person 4 | Person 5 | Person 6 |
|--|-----------|-----------|-----------|-----------|-----------|-----------|
| ● Tap water, directly from the faucet (that you do not filter)? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● Water from a refrigerator dispenser? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● Tap water that you filter (for example, filter in pitcher, on faucet, under sink)? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● Bottled water? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● Other (please specify) _____ | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |

For questions 15 and 16, it does not matter if you filter the water. (1 cup = ½ of a pint = 8 ounces)

| | | | | | | |
|--|------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|
| 15 On average, about how many cups of your home tap water does each person drink per day ? | Cups <input type="text"/> | Cups <input type="text"/> | Cups <input type="text"/> | Cups <input type="text"/> | Cups <input type="text"/> | Cups <input type="text"/> |
| 16 On average, about how many cups of cold drinks mixed with your home tap water, such as Kool-Aid, infant formula, instant iced tea, or watered-down juice, does each person drink per day ? Do not include hot beverages, like brewed coffee or tea. | Cups <input type="text"/> | Cups <input type="text"/> | Cups <input type="text"/> | Cups <input type="text"/> | Cups <input type="text"/> | Cups <input type="text"/> |

SECTION 6 RECENT ACTIVITIES

In this section, we are interested in recent activities you and your household members did during the 2-week period. Please refer to the label on the front of this booklet or the enclosed calendar for the dates of your 2-week period.

| | Person 1 (yourself) | Person 2 | Person 3 | Person 4 | Person 5 | Person 6 |
|--|------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Person's initials (copy from Question 11) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

17 During the **2-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 waded 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 |
| ● Spend any nights away from home? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● How many nights away from home? | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| ● Eat any meals prepared in a restaurant? (includes deli, fast food, take-out) | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● About how many restaurant meals? | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

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SECTION 7 STOMACH PROBLEMS

Please refer to the label on the front of this booklet or the enclosed calendar for the dates of the **2-week period**. In this section, we are asking about new stomach problems that started during the **2-week period**, 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) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

18 During the **2-week period**, did anyone start having **new stomach problems** (not problems they normally have)? Circle **Yes** or **No** for each person.

| | Person 1 (yourself) | Person 2 | Person 3 | Person 4 | Person 5 | Person 6 |
|---|------------------------|-----------|-----------|-----------|-----------|-----------|
| ● 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? (3 or more loose stools in a 24-hour period) | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● Abdominal pain or cramps? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● 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 each box.

| | | | | | | |
|---|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| 19 How many days did the stomach problems last? | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 20 When did the stomach problems start? (MM/DD/YY) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| This date is: | [] Exact [] Best guess | [] Exact [] Best guess | [] Exact [] Best guess | [] Exact [] Best guess | [] Exact [] Best guess | [] Exact [] Best guess |

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

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SECTION 8 ILLNESS DETAILS - STOMACH PROBLEMS

Please complete the section **only** if you answered Yes to **any** symptoms in **section 7**. If no one had stomach problems in the 2-week period, you can skip to **section 9** on the next page.

These questions are asking about how stomach problems during the 2-week period affected you.

| | Person 1 (yourself) | Person 2 | Person 3 | Person 4 | Person 5 | Person 6 |
|--|------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Person's initials (copy from Question 11) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Enter number of days missed, enter 0 if no school or work missed | | | | | | |
| 21 How many days of school or work did each person miss because of stomach problems? | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Circle Yes or No for each person. | | | | | | |
| 22 Did anyone see a healthcare provider for stomach problems ? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| 23 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 |
| 24 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 |
| Do you have any other information to share about recent stomach problems? | <hr/> <hr/> <hr/> | | | | | |

SECTION 9 OTHER RECENT ILLNESSES OR SYMPTOMS

Please refer to the label on the front of this booklet or the enclosed calendar for the dates of the **2-week period**. In this section, we are asking about new illness or symptoms that started during the **2-week period**, 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) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

25 During the **2-week period**, did anyone start having **any of the following new symptoms?**
Circle **Yes** or **No** for each person.

| | Person 1 (yourself) | Person 2 | Person 3 | Person 4 | Person 5 | Person 6 |
|---|------------------------|-----------|-----------|-----------|-----------|-----------|
| ● Cough? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● Sore throat? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● Running or stuffy nose? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● Shortness of breath? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● Rash? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● Eye infection (for example, pink eye)? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● Ear infection? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| ● Fever (100°F or higher) at the same time as these symptoms? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |

If anyone had **ANY** symptoms in question 25, please answer questions 26, 27 and 28.

Enter number of days missed, enter 0 if no school or work missed

| | | | | | | |
|---|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| 26 How many days of school or work did each person miss because of these symptoms? | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 27 Did anyone see a healthcare provider for these symptoms? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| 28 Was anyone admitted to the hospital for at least one day as a result of these symptoms? | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |

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