Attachment 19-2: BEEA Home Visit CAPI Instrument for Control Participants

Biological Sample Collection Questionnaire - Controls
Agricultural Health Study

Location of Residence (County, State): ____________________

Date: _____/______/______
MM DD YYYY

OMB #: 0925-0406
Expiration date: 09/30/2016

Public reporting for this collection of information is estimated to average 90 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: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0406). Do not return the completed form to this address.

PRE-INTERVIEW PREPARATION:

1. ASK PARTICIPANT FOR SHOWCARD WITH WORK HISTORY INFORMATION.
2. ASK PARTICIPANT FOR ASSEMBLED PRESCRIPTION MEDICATIONS.
3. PROVIDE CALENDAR TO PARTICIPANT FOR REFERENCE.

[Display subject ID and Participant information on CAPI "face sheet"]

Screening Questions To Ask Prior To Consent (SCR):

1a. Is your name ^DSP.Respondent_Fullname and is your date of birth ^STN.Respondent_Birthdate?
Yes _____ (Q2) No _____

1b. What is your correct date of birth? ______/_______/________
MM DD YYYY

1c. [INTERVIEWER] IS IT POSSIBLE THAT THE NUMBERS IN THE DATE OF BIRTH FROM OUR RECORDS (BIRTHDATE), COMPARED TO THE BIRTHDATE GIVEN (RESPONDENT BIRTHDATE) COULD HAVE BEEN TRANSPOSED, MISREAD, OR ARE REVERSED?
YES _____ (Q2a) NO _____

1d. Does another person with a similar name but a different date of birth live here?
Yes _____
No _____ (Skip to Q1g)

1e. May I please speak to the other (FULL NAME)?
Yes _____ THANK INITIAL/INCORRECT RESPONDENT; WAIT TO RECORD "YES" WHEN THE RESPONDENT IS READY TO BEGIN.
No _____

1f. Do you know a better time when we can reach the other (FULL NAME)?
____

RECORD INFORMATION ON AND BEST TIME TO REACH; THEN GO TO CLOSINGS.

1g. Do you know how we can reach the other (FULL NAME)?
____

RECORD INFORMATION ON HOW TO REACH (COLLECT PHONE AND BEST TIME TO REACH); THEN GO TO CLOSINGS.

2a According to your birthdate that we have on record, you should be ^DSP_Respondent_Age years old. Is this accurate?

YES _____ (Q3) NO _____

2b. What is your correct age? ______

IF <50 GO TO INELIGIBLE1

3. Do you have a blood clotting disorder such as hemophilia?
Yes _____ (GO TO INELIGIBLE2) No _____

4. Not including non-melanoma skin cancer, have you been diagnosed by a doctor with any type of cancer in the last three years?
Yes _____ No _____ (GO TO PER)

   a. In what organ or part of the body did your cancer start? (If you are not sure of the answer, please give me your best guess).
   b. In what year were you first diagnosed by a doctor with this cancer?

ENTER EACH CANCER AND DATE OF DIAGNOSIS.
1st cancer ____________________________Date of diagnosis _____/______/______
MM DD YYYY
2nd cancer (if applicable)________________ Date of diagnosis _____/______/_____
MM DD YYYY

Personal Information (PER):

1. How tall are you?
___________________feet / inches

2. How much do you weigh now? ___________________ pounds

3. **In the last 7 days**, have you used aspirin or aspirin-containing products, such as Bayer, Bufferin, Anacin or Excedrin? (Please do not include aspirin-free products such as Tylenol and Panadol.)
Yes _____ No _____ (Q4)

   a. What is the product name?: _______________
   b. What is the product strength? Would you say:
      Adult strength (usually 325mg), _____
      Baby strength (usually 81mg), _____
      Or some other strength? (SPECIFY) _____

c. How many pills of aspirin or aspirin-containing products have you taken in the **last 7 days**? ______
d. When did you last take aspirin or aspirin-containing products?
_____ days ago or _____ hours ago or _____ minutes ago

4. **In the last 7 days**, have you used ibuprofen-containing products, such as Advil, Nuprin, or Motrin?
Yes _____ No _____ (Q5)

a. What is the product name: _______________
b. How many pills of ibuprofen-containing products have you taken **in the last 7 days**? ____
c. When did you last take ibuprofen-containing products?
_____ days ago or _____ hours ago or_____ minutes ago

5. Are you regularly taking any blood thinning medications, such as Heparin, Coumadin, or plavix? Since we have already asked you about aspirin, you do not need to report that here.
Yes _____ No _____ (Q7)

6. Which blood thinning medication(s) do you regularly take?
a. HEPARIN
b. COUMADIN
c. PLAVIX
d. OTHER (SPECIFY) ____

7. In the last 30 days, have you taken any prescribed medicines?
Yes _____ No _____ (Q8)

a. Can you please tell me the name or names of the each prescription medication you are taking? REFER TO BOTTLES ASSEMBLED BY PARTICIPANT. REVIEW TOGETHER AND ENTER.

____

Next, I'm going to ask you about different conditions with which you may have been diagnosed. Please answer yes or no for each one.

8. Has a doctor or other medical professional ever told you you had:

	YES	NO
a. Heart disease?	1	2
b. High blood pressure or hypertension?	1	2
c. Diabetes?	1	2
d. Rheumatoid arthritis?	1	2
e. An autoimmune disease? (IF ASKED: multiple sclerosis, sarcoidosis, lupus, or Sjogren's disease)	1	2

The next series of questions deals with conditions or symptoms that you may have had within the **last 12 months**. If you need to, please use the calendar to help with your answers.

9. During the last 12 months, have you had any symptoms of hay fever, seasonal allergies or allergic rhinitis? Examples of symptoms include having a stuffy, itchy or runny nose or watery, itchy eyes. Please do not include symptoms related to a cold or the flu.
   Yes _____ (Q9.a) No _____ (Q10)

   a. In the last 12 months, what allergy symptoms have you had? (select all that apply)
      Stuffy, itchy or runny nose
      Watery, itchy eyes
      Sinusitis or sinus pain or pressure
      Other symptoms:______________

   b. On how many days did you have symptoms of allergies within the last 30 days?
      _____ days [0-30]

   c. On how many days did you have symptoms of allergies within the last 7 days?
      _____ days [0-7]

   d. Have you had any symptoms of allergies yesterday or today?
      Yes _____ No _____

   e. Did you use any medications to treat or prevent allergy symptoms?
      Yes _____ No _____ (Q10)

   f. Please list the medications you used to treat your allergies.

      Name of medication(s): __________

10. During the last 12 months, have you had any itching or other symptoms of eczema?
    Yes _____ (Q10.a) No _____ (Q11)

    a. Have you had symptoms of eczema in the last 30 days?
       Yes _____ (Q10.b) No _____ (Q10.d)

    b. Have you had symptoms of eczema in the last 7 days?
       Yes _____ (Q10.c) No _____ (Q10.d)

    c. Have you had symptoms of eczema yesterday or today?
       Yes _____ (Q10.d) No _____ (Q10.d)

    d. Did you use any medications to treat eczema?
       Yes _____ (Q10.e) No _____ (Q11)

    e. Please list the medications you used to treat your eczema: __________

11. During the last 12 months, have you had an episode of asthma or an asthma attack?
    Yes _____ (Q11.a) No _____ (Q12)

a. Have you had any symptoms of asthma or an asthma attack in the last 30 days?
Yes _____ (Q11.b) No _____ (Q11.d)

b. Have you had any symptoms of an asthma or asthma attach in the last 7 days?
Yes _____ (Q11.c) No _____ (Q11.d)

c. Have you had any symptoms of asthma or asthma attack yesterday or today?
Yes _____ (Q11.d) No _____ (Q11.d)

d. Did you use any medications for asthma or asthma attack?
Yes _____ (Q11.e) No _____ (Q12)

e. Please list the medications you used to treat your asthma.
Name of medication(s): __________

The next series of questions deals with conditions that you may have had within the **last 30 days**. If you need to, please use the calendar to help with your answers.

12. In the **last 30 days**, have you had:

a. A Cold or flu? Yes _____ No _____ (Q12b)
When did symptoms begin? ______/_______/________
MM DD YYYY
When did symptoms resolve? _____/_______/________
MM DD YYYY

b. (In the **last 30 days**, have you had) bronchitis or pneumonia?
Yes _____ No _____ (Q12c)
When did symptoms begin? ______/_______/________
MM DD YYYY
When did symptoms resolve? _____/_______/________
MM DD YYYY

c. (In the **last 30 days**, have you had) sinusitis or sinus problems?
Yes _____ No _____ (Q12d)
When did symptoms begin? _____/_______/________
MM DD YYYY
When did symptoms resolve? _____/_______/________
MM DD YYYY

d. Have you had any other type of infection (in the last 30 days)?
Yes _____ No _____ (Q13)
List type(s)____
When did symptoms begin? _____/_______/________
MM DD YYYY
When did symptoms resolve? _____/_______/________
MM DD YYYY

Now I'm going to ask about medical or dental x-rays or any other radiologic procedures you may have had during the **last 12 months**.

13. **During the last 12 months/Since your last visit**, have you had (any/a):

Type of Procedure	IF YES: When did you have the [Type of Procedure]?
a) Medical x-rays?	(mm/dd/yyyy)
b) Dental x-rays?	(mm/dd/yyyy)
c) CT scan or CAT Scan?	(mm/dd/yyyy)
d) Fluoroscopy?	(mm/dd/yyyy)
e) PET scan?	(mm/dd/yyyy)
f) Diagnostic radioisotopes, for example a thallium stress test?	(mm/dd/yyyy)
g) Other type of radiologic procedure?	(mm/dd/yyyy)

14. How many servings of alcoholic beverages did you drink in the last seven days? A serving of an alcoholic beverage is defined as 12 fluid ounces of beer, 5 fluid ounces of wine, and 1.5 fluid ounces of hard liquor. Number of servings: ___________

    IF NUMBER OF SERVINGS = 0 (NONE), GO TO Q16_INTRO.

15. How many servings of alcoholic beverages did you drink in the last 24 hours? A serving of an alcoholic beverage is defined as 12 fluid ounces of beer, 5 fluid ounces of wine, and 1.5 fluid ounces of hard liquor. Number of servings: ___________

The next series of questions deals with your tobacco use.

16. Do you currently smoke cigarettes, a pipe, or cigars, or use other tobacco products such as chewing tobacco or snuff?

    Yes _____ No _____ (OAG)

17. How often do you (smoke/use) [Product]? (Would you say every day, some days or not at all?)

Product	Every day	Some days	Not at all
Cigarettes			
A pipe			
Cigars			
Cigarillos			
Chewing tobacco			
Snuff			
Do you smoke or use any other type of tobacco products? (SPECIFY)			

Other agricultural exposures section (OAG)

Next I want to ask you a few questions about whether you have ever lived on a farm or performed farm work.

1. Have you ever lived on a farm?
   Yes _____ No _____ (go to OCC)

2. At what age did you first live on a farm?
   _____ [0-99]

3. In total, how many years did you spend living on a farm?
   a. Before age 18:
   b. Over your entire lifetime:

4. Since the age of 18, have you personally performed farm work or farming activities?
   Yes _____ No _____ (HOM)

5. When did you last perform farm work or farming activities?
   ___/___/______ OR ____ YEARS AGO
   MM DD YYYY

Home and Garden Pesticide Use Questions (HOM)

I would now like to ask about your use of pesticides around your home and garden in the last 12 months. This includes the use of herbicides, insecticides, fungicides, fumigants, or other chemicals used to kill plants, insects, fungi, molds, or rodents. Please do not include the use of antibiotics, sanitizers, antimicrobial soaps or fertilizers.

1. In the last 12 months, have you personally used pesticides in your home and garden?

   Yes _____ No _____ (GO TO Q3.)

2. Which products have you used in your home and garden in the last 12 months? Please give the product trade name, if possible:
   ____

   IF OTHER: Please give the product trade name, if possible. __________________

   IF OTHER: If label is available, what is the active ingredient in [OTHER]? __________________

   IF OTHER: What is the EPA Registration number for [OTHER]? _________________

3. Do you or does anyone in your household have any pets or other animals, such as dogs, cats, or horses?
   Yes _____ No _____ (OCC)

4. How many [Type] do you have?

Type	NUMBER:
Dogs	
Cats	
Horses	
Poultry	
Poultry for eggs	
Other animals (SPECIFY)	

Occupation Information (OCC)

In this next section, I am going to ask you about the kind of work you have done since you were at least 18 years old. Before I do that, I'd like to review the Work History Calendar you completed. REVIEW THE JOB AND COMPANY COLUMNS OF THE WORK HISTORY CALENDAR WITH THE PARTICIPANT. IF THE CALENDAR HAS NOT BEEN COMPLETED, ASK PARTICIPANT TO COMPLETE IT BEFORE CONTINUING.

1. Have you held any part-time jobs for a total of at least 12 months that you have not reported on this calendar already? For example, please count a 3-month part-time job that you held for 4 years. Include only jobs you've held when you were at least 18 years old.

   Yes _____ No _____

ADD ADDITIONAL JOBS TO CALENDAR. DETERMINE WHICH JOBS WERE HELD FOR >= 12 MONTHS AND PLACE A CHECK MARK NEXT TO THEM ON THE CALENDAR. THESE JOBS QUALIFY TO BE ENTERED IN CAPI.

2. [INTERVIEWER: HOW MANY JOBS QUALIFY?]

   NONE _____ (CLOSINGS)
   ONE _____
   TWO OR MORE _____

ENTER THE START YEAR, JOB TITLE, EMPLOYER NAME AND STOP YEAR FOR EACH JOB LISTED ON THE WORK HISTORY CALENDAR WITH A CHECK MARK NEXT TO IT.

IF ASKING ABOUT SAME EMPLOYER FOR > 1 JOB, VERIFY OC-3 AND OC-4. OC-3. What type of business {is/was} this? [INTERVIEWER: SELECT ALL THAT APPLY.]	OC-4. What did {Employer Name} make, or what service did they provide?	OC-4a. On average how many days per week did you work on this job?	OC-5. How many months per year did you usually work on this job?	OC-6. About how many hours per week did you usually work on this job?
MANUFACTURING .... 10 A RETAIL STORE.................... 11 WHOLESALE OR DISTRIBUTOR .... 12 A SERVICE PROVIDER .... 13 CONSTRUCTION..................... 14 MINING..................................... 15 FARMING, FISHING, OR FORESTRY .... 16 GOVERNMENT OR MILITARY .... 17 A SHIPYARD............................ 18 SOME OTHER TYPE OF BUSINESS (SPECIFY) .... 91 ______________________________	______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________ __________________________	|___| DAYS PER WEEK	|___|___| MONTHS PER YEAR	|___|___| HOURS PER WEEK

IF START YEAR <> DK OR RF AND STOP YEAR <> DK OR RF, GO TO OC-7. OTHERWISE, CONTINUE WITH OC-6a.

OC-6a Did you work at this job:	OC-7. What were your main activities or duties at this job?	OC-8. What kinds of chemicals or materials, if any, did you handle? Do not include standard office materials. TYPE “none” IF NO CHEMICALS WERE HANDLED.	OC-9. What kinds of tools and equipment, if any, did you use? Do not include computers or standard office equipment. TYPE “none” IF NO EQUIPMENT WAS USED.
Less than 5 years.........1 5 to 10 years, or...........2 More than 10 years......3	____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________	____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________	____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________

Closings

COMPLETE INTERVIEW
This concludes the interview portion of the visit. I appreciate your taking the time with me to answer these questions. Now I am going to get set up for the blood draw.

Interviewer Remarks

R1. PARTICIPANT'S COOPERATION WAS:
1. VERY GOOD
2. GOOD
3. FAIR
4. POOR

R2. THE OVERALL QUALITY OF THIS INTERVIEW IS:
1. HIGH QUALITY
2. GENERALLY RELIABLE
3. QUESTIONABLE
4. UNSATISFACTORY

NO INTERVIEW1
Ok, then. Thank you very much.

NO INTERVIEW2
I'm sorry for the confusion. That is all the questions I have for you at this time. Thank you for speaking with me today.

NO INTERVIEW3
That is all the questions I have for you at this time. Thank you for speaking with me today.

INELIGIBLE 1: I apologize. Our records indicated that you were within the age range we are including in the study. However, based on this updated information on your age, you are not eligible for this study. Thank you for your time today.

INELIGIBLE 2: Unfortunately, you are not eligible for this study: we are looking for a group of men who are able to provide blood samples. Thank you for your time today