

**Self-reported Rash Symptoms and Exposure to Flint Water**  
**MDHHS Questionnaire**

*Note to the interviewer: script in italics is clarification for you, and is not to be read aloud to the interviewee. Please do not prompt answers (e.g. read out options “Yes”, “No”, “Don’t Know”, “Refused”) unless noted to.*

INTRODUCTION SCRIPTS

For people referred through 211/CHECC and home visits:

Hello, my name is \_\_\_\_\_, and I work for the [*Michigan Department of Health and Human Services/Agency for Toxic Substances and Disease Registry/Centers for Disease Control and Prevention*]. We are working with the [*Michigan Department of Health and Human Services/Agency for Toxic Substances and Disease Registry/Centers for Disease Control and Prevention*] looking into reported rash symptoms related to exposure to Flint tap water. We received your name because you have reported rash symptoms [*to the 211 phone number OR to an MDHHS or CDC representative who visited your home recently*]. We would like to ask you some questions about your health, the health of your family, and your tap water usage. Your answers will help us understand what symptoms have been reported since the City of Flint switched its water source. The questions will take about 20 minutes. May we go ahead now with the questionnaire?

For people referred through healthcare providers:

Hello, my name is \_\_\_\_\_, and I work for the [*Michigan Department of Health and Human Services/Agency for Toxic Substances and Disease Registry/Centers for Disease Control and Prevention*]. We are working with the [*Michigan Department of Health and Human Services/Agency for Toxic Substances and Disease Registry/Centers for Disease Control and Prevention*] looking into reported rash symptoms related to exposure to Flint tap water. We received your name because you visited a healthcare provider to report rash symptoms and they forwarded your information to us. We would like to ask you some questions about your health, the health of your family, and your tap water usage. Your answers will help us understand what symptoms have been reported since the City of Flint switched its water source. The questions will take about 20 minutes. May we go ahead now with the questionnaire?

*If yes, participation in this questionnaire is voluntary: if you feel uncomfortable answering any question, you do not have to answer and you may stop the interview at any time. However, any information you can provide will help us immensely.*

*IF NO, is there a convenient time when I can call you back?*

Day: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Telephone: \_\_\_\_\_

Public reporting burden of this collection of information is estimated to average 20 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 Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0923-0051)



2. First, I have a few questions about you (or your child/friend, if interviewing for another person).

2a. How old are you? \_\_\_\_\_

2b. What is your sex?

- Male  
 Female

2c. Do you currently work?

- No  
 Yes  
 Refused  
 Don't know

2c1. IF YES, can you please explain what you do? \_\_\_\_\_

### HISTORY OF ILLNESS

3. As I mentioned before, we received your name because you reported symptoms. I am going to ask you about these symptoms.

3a. Did you experience a rash?

- No  
 Yes  
 Don't know  
 Refused

IF YES, on what parts of your body did the rash occur?

- Face       Arms       Feet  
 Neck       Hands       Other  
 Torso       Legs      Explain: \_\_\_\_\_

IF YES, how big was the rash? (at widest)

- 0-3 inches  
 3-5 inches  
 > 5 inches  
 Don't know  
 Refused

3a1. When did your rash start? Date: \_\_\_\_\_

3a1a. Have your symptoms improved, gotten worse, or stayed the same since October 16, 2015?

- Improved  
 Gotten worse  
 Stayed the same  
 Refused  
 Don't know

(Note: On October 16, 2015, City of Flint switched back to buying water from Detroit)

3a2. Do you still have a rash?

- No  
 Yes  
 Don't know  
 Refused

Can you please describe your rash for me?

3a3. Hives (raised patches)?

- No  
 Yes  
 Don't know  
 Refused

3a4. Raised bumps?

- No  
 Yes  
 Don't know  
 Refused

3a5. Dry or flakey skin?

- No  
 Yes  
 Don't know  
 Refused

3a6. Itchy skin?

- No  
 Yes  
 Don't know  
 Refused

3a7. Painful skin?

- No  
 Yes  
 Don't know  
 Refused

3a8. Other?

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

3a9. What activities cause the rash to occur?

- Washing dishes  
 Doing laundry

- Showering  
 Taking a bath

- Drinking water  
 Other, please explain \_\_\_\_\_

Cooking

Using a hot tub

3a10. Once the rash appears, how long does it take to go away? \_\_\_\_\_

- Hours
- Days
- Has not gone away
- Don't know
- Refused

3a11. What makes the rash feel better? \_\_\_\_\_

3a12. What makes the rash feel worse? \_\_\_\_\_

3a13. Were you taking any new medicines when the rash started?

- No
- Yes
- Don't know
- Refused

*IF YES, what kind?* \_\_\_\_\_

Did you experience any other symptoms with the rash? Such as...

3b. Numbness or tingling?

- No
- Yes
- Don't know
- Refused

*IF YES, Where did the numbness or tingling occur?*

- Face
  - Neck
  - Torso
  - Arms
  - Hands
  - Legs
  - Feet
  - Other
- Explain \_\_\_\_\_

3c. Fever?

- No
- Yes
- Don't know
- Refused

*IF YES, how high?*

**Time Course**

When did your fever begin?

When did your fever end?

3d. Shortness of Breath?

- No
- Yes
- Don't know
- Refused

When did your s.o.b. begin?

When did your s.o.b. end?

3e. Wheezing?

- No
- Yes
- Don't know
- Refused

When did your wheezing begin?

When did your wheezing end?

3f. Diarrhea?

- No
- Yes
- Don't know
- Refused

When did your diarrhea begin?

When did your diarrhea end?

3g. Eye Irritation?

- No
- Yes
- Don't know
- Refused

When did the irritation begin?

When did the irritation end?

**3h. Hair Loss?** Please describe: **Quantity** **Location on scalp**  
 (e.g. strands, chunks) (e.g. patchy, right side, etc.)

No  
 Yes  
 Don't know  
 Refused

**3i. Anything Else?** Please describe: **Time Course**  
 When did this symptom begin? When did this symptom end?

No  
 Yes  
 Don't know  
 Refused

**Now I would like to ask you a few questions about your tap water use.**

**4. Is your home on municipal water, that is, do you get your water from the City of Flint?**

- No
- Yes
- Refused
- Don't know

**4b. IF NO, can you tell me the source of your tap water?** \_\_\_\_\_

**5. Do or did you have contact with Flint Water outside of your home?**

- No
- Yes
- Refused
- Don't know

**5a. IF YES, can you please explain where?** \_\_\_\_\_

**5b. IF YES, when did you start using Flint water at this location?**

\_\_\_\_\_

**5c. IF YES, when did you stop using Flint water at this location?**

\_\_\_\_\_

**5d. Have your symptoms improved or gone away since you changed your water use at this location?**

- Improved
- Gotten worse
- Stayed the same
- Have not changed water use
- Refused
- Don't know

**6. When your symptoms started, did you notice changes in your tap water quality (appearance, taste, smell) at home?**

- No
- Yes
- Refused
- Don't know

**6a. IF YES, can you please describe the change in water quality?** \_\_\_\_\_

\_\_\_\_\_

**7. When your symptoms started, did you notice changes in your water pressure at home?**

- No
- Yes
- Refused
- Don't know

7a. IF YES, did the water pressure:  Increase?  Decreased

8. Are you using a water filter for your water at home?

- No
- Yes
- Refused
- Don't know

8a. What type of filter are you using at home?

- Brita
- PUR
- Other \_\_\_\_\_

8b. When did you start using the filter?

\_\_\_\_\_

Date:

8c. How are you using your filter?

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

9. Are you using a different water source than normal for the following activities?

- Washing dishes
- Doing laundry
- Cooking, explain \_\_\_\_\_
- Showering
- Taking a bath
- Using a hot tub
- Drinking water, explain \_\_\_\_\_
- Brushing teeth, explain \_\_\_\_\_
- Other, please explain \_\_\_\_\_
- Refused
- Don't know

10. Have you changed your behavior or habits for bathing and/or showering?

- No
- Yes
- Refused
- Don't know

IF YES, can you please explain how your bathing habits have changed in the following ways:

10a. Frequency

- Shower less frequently
- Shower more frequently
- Don't know
- Refused

10b. Length

- Shorter showers
- Longer showers
- Don't know
- Refused

10c. Method

Please explain: (e.g. use of wipes, sponges)

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

11. Do you add anything to your water before using it?

- No
- Yes
- Refused
- Don't know

11a. IF YES, please explain what you add (optional: and the amount you use):

*Ask about amount if it makes sense based on what they are adding*

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**12. Have you changed your tap water use in any other way?**

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**13. When did you start making these changes to your tap water use?**

Date \_\_\_\_\_

**14. Have your symptoms improved, gotten worse, or stayed the same since you changed your water use?**

- Improved
- Gotten worse
- Stayed the same
- Refused
- Don't know

**15. What most influenced you to start making these changes to your tap water use?**

- Symptoms
- Concerns for health
- Media
- Doctor's advice
- Other, please explain \_\_\_\_\_

**SEEKING CARE**

*Note: Please ask these questions of all participants, including those referred by Poison Control.*

**16. Did you seek medical attention for any of the symptoms we just talked about?**

- No
- Yes
- Refused
- Don't know

**IF NO, it is important that you go see your primary care doctor or a physician for further evaluation.**

**SKIP TO 17.**

**IF YES:**

**16a. Where did you go? (check all that apply)**

- Primary Care Provider
- Emergency Department
- Urgent care
- Specialist (e.g. dermatologist, eye doctor, etc.)
- Alternative health care provider
- Other Explain: \_\_\_\_\_

**16b. Were you hospitalized for this condition?**

- Yes
- No
- Refused
- Don't know

16b1. IF YES, when? \_\_\_\_\_

16c. Did you receive a diagnosis?

- No
- Yes
- Refused
- Don't know

16c1. IF YES, what was the diagnosis? \_\_\_\_\_

16d. Did you receive treatment?

- No
- Yes
- Refused
- Don't know

16d1. IF YES, what was the treatment? \_\_\_\_\_

16e. Do you give permission for us to speak to your doctor (or dermatologist) and access your medical records about these visits to your doctor/the hospital? Medical records are very useful and enable us to add additional details to the information you have already given us. We will not access any other part of your medical records.

- No
- Yes

Please provide your doctor's name and contact information

16e1. Name: \_\_\_\_\_

16e2. Phone Number: \_\_\_\_\_

17. Have you tried any treatments or medications on your own?

- No
- Yes
- Refused
- Don't know

17a. IF YES, what was the treatment? \_\_\_\_\_

### GENERAL HEALTH

Now I am going to ask you a few questions about your general health.

18. Has a doctor ever told you that you have any chronic health conditions, such as diabetes, heart disease, or lung disease?

- No
- Yes
- Refused
- Don't know

18a. IF YES, what are they? \_\_\_\_\_  
\_\_\_\_\_

18b. When were you told about this / these conditions? Date: \_\_\_\_\_



19. Has a doctor ever told you that you have asthma or seasonal allergies?

- No
- Yes
- Refused
- Don't know

19a. IF YES, what are they? \_\_\_\_\_  
\_\_\_\_\_

19b. When were you told about this / these conditions? Date: \_\_\_\_\_

20. Has a doctor ever told you that you have a skin condition, including psoriasis, eczema, or dermatitis?

- No
- Yes
- Refused
- Don't know

20a. IF YES, what skin conditions? \_\_\_\_\_  
\_\_\_\_\_

20b. When were you told about this / these conditions? Date: \_\_\_\_\_

21. Do you have any allergies to metals, foods, or anything else?

- No
- Yes
- Refused
- Don't know

21a. IF YES, what are they? \_\_\_\_\_  
\_\_\_\_\_

21b. When were you tested for this / these conditions? Date: \_\_\_\_\_

22. Do you currently take any medications?

- No
- Yes
- Refused
- Don't know

22a. IF YES, what are they? \_\_\_\_\_  
\_\_\_\_\_

23. Are you currently a smoker?

- No
- Yes
- Refused
- Don't know

23a. IF YES, how many packs per day? \_\_\_\_\_



