## Attachment 7

**Symptom Survey** 

Form Approved OMB No. 0920-0079 Exp. Date XX/XX/XXXX

# Fleisch-Kincaid Reading Level: 5.6 Aerosols from cyanobacterial blooms: exposures and health effects in highly exposed populations

#### **Symptom Survey**

Date:	mm dd yyyy
Time:	AM PM
Your a	ssigned study ID number:

CDC estimates the average public reporting burden for this collection of information as 15 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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 (0920-0079).

PART 1: Pre-exposure symptom survey: Please answer the following questions.

Do you currently have a head cold, chest cold, flu, or pneumonia?

No	1
Yes	2
Don't know	8
Refused	9

Do you currently have a gastrointestinal illness, such as a stomach ache?

No	1
Yes	2
Don't know	8
Refused	9

Please tell me if you have experienced any of the following symptoms or problems within the last 7 days. If you did have that symptom or problem, please tell me when it started and when it ended, and whether you still have the symptom or problem. Note that the start date may have been before the last 7 days.

Symptom or Problem	When did it start?	Do you still have the symptom or problem?	When did it end?
	1	i	
Fever			
? Y		? Y	
? N	DD MM YY	? N	DD MM YY
Chills			
? Y	/	? Y	/
? N	DD MM YY	? N	DD MM YY
Headache			
? Y	/	? Y	/
? N	DD MM YY	? N	DD MM YY
Sore throat			
? Y	/	? Y	/
? N	DD MM YY	? N	DD MM YY
Ear ache			
? Y	/	? Y	/
? N	DD MM YY	? N	DD MM YY
Discharge or fluid running from			
ear	/	? Y	/
? Y	DD MM YY	? N	DD MM YY
? N			

Symptom or Problem	When did it start?	Do you still have the symptom or problem?	When did it end?
Abdominal pain			
? Y	/	? Y	/
? N	DD MM YY	? N	DD MM YY
Nausea			
? Y	/	? Y	/
? N	DD MM YY	? N	DD MM YY
Vomiting			
? Y	/	? Y	/
? N	DD MM YY	? N	DD MM YY
Diarrhea			
? Y		? Y	
? N	DD MM YY	? N	DD MM YY
Diarrhea with blood			
? Y	/	? Y	/
? N	DD MM YY	? N	DD MM YY
Other general symptoms or			
problems			
(specify)			, ,
? Y			/
? N	DD MM YY	? Y	DD MM YY
		? N	
Blurred Vision			, ,
? Y		? Y	
? N	DD MM YY	? N	DD MM YY
Irritation or pain			, ,
? Y		? Y	
? N	DD MM YY	? N	DD MM YY
Redness or discharge from eyes			, ,
? Y	//	? Y	
? N	DD MM YY	? N	DD MM YY
Conjunctivitis (Pink eye)	, ,		, ,
? Y	DD MM YY	? Y	//
? N	אן וייווייו טט	? N	א ויוויו טט ן
Other eye problems	, ,		, ,
(specify)		? Y	DD MM YY
? Y	DD MM YY	? N	ן ויוויו טט ן א
? N			

	When did it	Do you still	When did it end?
Symptom or Problem	start?	have the	
		symptom or	
		problem?	
Cough or choke	, ,		, ,
? Y	DD MM YY	? Y	DD MM YY
	ויוייו טט	? N	ויוויו טט
Shortness of breath	/ /	? Y	/ /
2 N	DD MM YY	? N	DD MM YY
Nasal congestion or runny nose		: IN	
Nasai congestion of runny nose	/ /	? Y	/ /
2 N	DD MM YY	? N	DD MM YY
Throat irritation		LIN	
? Y	/ /	? Y	/ /
? N	DD MM YY	? N	DD MM YY
Other breathing-related			
symptoms			
(specify)	/	? Y	/
? Y	DD MM YY	? N	DD MM YY
? N			
Asthma-related symptoms: Just as a reminder for me, has a doctor, nurse, or other health professional ever told you that you had asthma?  No (SKIP TO next section) Yes 2 Don't know (SKIP TO NEXT SECTION) 8 Refused (SKIP TO NEXT SECTION) 9			
	1	T _	T
Wheezing	/ /	? Y	
? Y	DD MM YY	? N	//
? N	DD 141141 11	? Y	DD MM YY
Coughing Y	/ /	? N	, ,
? N	DD MM YY	L IN	DD MM YY
Trouble breathing		? Y	וז ויוויו עט וז
? Y	//	? N	/ /
? N	DD MM YY		DD MM YY
Other asthma-related symptoms			
(specify)		? Y	/ /
② Y	/	? N	DD MM YY

Symptom or Problem	When did it start?	Do you still have the symptom or problem?	When did it end?
? N	DD MM YY		
Nerve-related symptoms.			
Agitation		? Y	
? Y	/	? N	/
? N	DD MM YY		DD MM YY
Confusion		? Y	
? Y	/	? N	/
? N	DD MM YY		DD MM YY
Dizziness		? Y	
? Y	/	? N	/
? N	DD MM YY		DD MM YY
Lethargy		? Y	
? Y	/	? N	/
? N	DD MM YY		DD MM YY
Loss of consciousness		? Y	
? Y	/	? N	/
? N	DD MM YY		DD MM YY
Weakness		? Y	
? Y	/	? N	/
? N	DD MM YY		DD MM YY
Seizures		? Y	
? Y	/	? N	/
? N	DD MM YY		DD MM YY
Numbness		? Y	
? Y	/	? N	/
? N	DD MM YY		DD MM YY
Tremor		? Y	
? Y	/	? N	/
? N	DD MM YY		DD MM YY
Other nerve-related symptoms		? Y	
(specify)	/	? N	/
? Y	DD MM YY		DD MM YY
? N			
Skin-related symptoms			

Symptom or Problem	When did it start?	Do you still have the symptom or problem?	When did it end?
Itchy skin		? Y	
? Y	/	2 N	/
? N	DD MM YY		DD MM YY
Red skin		? Y	
? Y	/	? N	/
? N	DD MM YY		DD MM YY
Hives or welts		? Y	
? Y	/	? N	/
? N	DD MM YY		DD MM YY
Skin irritation/pain		? Y	
? Y	/	? N	/
? N	DD MM YY		DD MM YY
Rash (describe)	/ /	? Y ? N	/ /
? Y	DD MM YY		DD MM YY
② N			
Infected cuts or scrapes		? Y	
? Y	/	? N	/
2 N	DD MM YY		DD MM YY
		? Y	
Oher skin-related symptoms		2 N	/
(specify)	/		DD MM YY
? Y	DD MM YY		
? N			

# Now, I just have a few more questions about your household pets

1P. Do you have any pets?	
No (SKIP TO END)	
Yes	2
Don't know (SKIP TO END)	8
Refused (SKIP TO END)	9
If yes, please describe:	
Dog	1
Cat	2

Horse Other	3
Other	
2P. Do your pets go into the water?	
No (SKIP TO END)	
Yes	2
Don't know (SKIP TO END)	8
Refused (SKIP TO END)	9
3P. Have any of your pets been sick after go	oing in the water?
No (SKIP TO END)	
Yes	2
Don't know (SKIP TO END)	8
Refused (SKIP TO END)	9
4P. Can you describe the sickness your pet	had?
Describe:	
5P. Did you see a veterinarian about your p	et's sickness?
No (SKIP TO 6P)	or a diditireda.
Yes	2
Don't know (SKIP TO 6P)	8
Refused (SKIP TO 6P)	9
5Pa. What was the diagnosis?	
Describe:	
What medications did your veterina	rian prescribe for your pet?
Describe:	
6P. Is your pet well now?	
No	
Yes	2
Don't know	8
Refused	9
6Pa. If your pet is not well now, car	you tell me what is wrong with

Thank you	hank you.
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## **Pulmonary function test results**

Parameter	Value
Forced vital capacity (FVC) in L	
Forced expiratory volume in the first second	
you exhale (FEV <sub>1</sub> ) in L/sec.	
Forced expiratory volume in the first second	
over forced vital capacity (FEV <sub>1</sub> /FVC) in %	
Forced expiratory flow from 25% to 75% of	
vital capacity (FEF <sub>25%-75%</sub> ) in L/sec	
Peak expiratory flow rate (PEF) in L/sec.	

Thank you for being in our study.

### **SURVEY PART 2: POST EXPOSURE SYMPTOM SURVEY**

Thank you for coming back for the second part of our study today. We can get started on the questions.

Did you notice any cyanobacteria (also called blue-green algae) blooms?  ? Yes ? No ? Not sure
Was the water discolored?
? Yes
? No
Not sure
If it was discolored, what color(s) did you notice?
② Red
2 Brown
<pre>     Green </pre>
? Black
? Yellow
? White
② Not sure
Did you notice an unusual odor?
? Yes
? No
② Not sure
If you noticed an unusual odor, can you describe it?
Did you see any dead fish?
Yes
? No
? Not sure
If you saw dead fish, do you know about how many dead fish you saw?

Now, please tell me if you have experienced any of the following symptoms or problems today. If you did have that symptom or problem, please tell me when it started and when it ended, and whether you still have the symptom or problem.

Symptom or Problem	When did it start?	Do you still have the symptom or problem?	When did it end?
Fever		? Y	
? Y	am pm	? N	am pm
? N			
Chills		? Y	
? Y	am pm	? N	am pm
? N			
Headache		? Y	
? Y	am pm	? N	am pm
? N			
Sore throat		? Y	
? Y	am pm	? N	am pm
? N			
Ear ache		? Y	
? Y	am pm	? N	am pm
? N			
Discharge or fluid running from		? Y	
ear	am pm	? N	am pm
? Y			
? N			
Abdominal pain		? Y	
? Y	am pm	? N	am pm
? N			
Nausea		? Y	
? Y	am pm	? N	am pm
? N			
Vomiting		? Y	
? Y	am pm	? N	am pm
? N			
Diarrhea		? Y	
? Y	am pm	? N	am pm
2 N			
Diarrhea with blood		? Y	

Symptom or Problem	When did it start?	Do you still have the symptom or problem?	When did it end?
? Y ? N	am pm	? N	am pm
Other general symptoms or problems (specify)  ? Y  ? N	am pm	? Y ? N	am pm
Eye-related symptoms			
Blurred Vision ② Y ② N	am pm	? Y ? N	am pm
Irritation or pain ② Y ② N	am pm	? Y ? N	am pm
Redness or discharge from eyes  ? Y ? N	am pm	? Y ? N	am pm
Conjunctivitis (Pink eye)  ? Y ? N	am pm	? Y ? N	am pm
Other eye problems (specify)  ? Y ? N	am pm	? Y ? N	am pm

Symptom or Problem	When did it start?	Do you still have the symptom or problem?	When did it end?	
Breathing-related symptoms				
Cough or choke		? Y		
? Y	am pm	? N	am pm	
? N				
Shortness of breath		? Y		
? Y	am pm	? N	am pm	
? N				
Nasal congestion or runny nose		? Y		
? Y	am pm	? N	am pm	
? N				
Throat irritation		? Y		
? Y	am pm	? N	am pm	
? N				
Other breathing-related symptoms		? Y		
(specify)	am pm	? N	am pm	
? Y				
? N				

## Asthma-related symptoms.

Wheezing	am pm	? Y	am pm
? Y		? N	
? N			
Coughing	am pm	? Y	am pm
? Y		? N	
? N			
Trouble breathing	am pm	? Y	am pm
? Y		? N	
? N			
Other asthma-related symptoms	am pm	? Y	am pm
(specify)		? N	
? Y			
? N			

Nerve-related symptoms.

Agitation		? Y	
? Y	am pm	? N	am pm
? N	'		'
Confusion		? Y	
? Y	am pm	? N	am pm
? N			
Dizziness		? Y	
? Y	am pm	? N	am pm
? N	'		'
Lethargy		? Y	
? Y	am pm	? N	am pm
? N	'		'
Loss of consciousness		? Y	
? Y	am pm	? N	am pm
? N			
Weakness		? Y	
? Y	am pm	? N	am pm
? N			
Seizures		? Y	
? Y	am pm	? N	am pm
? N			
Numbness		? Y	
? Y	am pm	? N	am pm
? N			
Tremor		? Y	
? Y	am pm	? N	am pm
? N			
Other nerve-related symptoms		? Y	
(specify)	am pm	? N	am pm
? Y			
? N			
	•	•	•

Itchy skin		? Y	
? Y	am pm	? N	am pm
? N			
Red skin		? Y	
? Y	am pm	? N	am pm
? N			
Hives or welts		? Y	
? Y	am pm	? N	am pm
? N			
Skin irritation/pain		? Y	
? Y	am pm	? N	am pm
? N			
Rash (describe)		? Y	
	am pm	? N	am pm
? Y			
? N			
Infected cuts or scrapes		? Y	
? Y	am pm	? N	am pm
? N			
Oher skin-related symptoms		? Y	
(specify)	am pm	? N	am pm
? Y			
? N			

Did anyone on your boat (other than you) complain about symptoms during your trip?

? Yes ? No	
If someone did complain about symptoms	s, what were the symptoms?
	- -

Pulmonary function test results (to be included for the three appointments only)

Parameter	Value
Forced vital capacity (FVC) in L	
Forced expiratory volume in the first second you exhale ( $FEV_1$ ) in L/sec.	
Forced expiratory volume in the first second over forced vital capacity (FEV <sub>1</sub> /FVC) in %	
Forced expiratory flow from 25% to 75% of vital capacity (FEF <sub>25%-75%</sub> ) in L/sec	
Peak expiratory flow rate (PEF) in L/sec.	

#### \*\*REMINDERS\*\*:

- 1. Please collect a urine specimen and leave it with study staff.
- 2. Please collect a nasal swab and leave it with study staff.
- 3. Please make sure study staff remove the air sampling pump from your boat.
- 4. Please provide study staff with the fish if you caught one today.
- 5. Please collect your gift card from study staff.

Thank you for being in our study.