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 assigned study ID number: _____

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?
Fever ☐ Y ☐ N	____/____/____ DD MM YY	☐ Y ☐ N	____/____/____ DD MM YY
Chills ☐ Y ☐ N	____/____/____ DD MM YY	☐ Y ☐ N	____/____/____ DD MM YY
Headache ☐ Y ☐ N	____/____/____ DD MM YY	☐ Y ☐ N	____/____/____ DD MM YY
Sore throat ☐ Y ☐ N	____/____/____ DD MM YY	☐ Y ☐ N	____/____/____ DD MM YY
Ear ache ☐ Y ☐ N	____/____/____ DD MM YY	☐ Y ☐ N	____/____/____ DD MM YY
Discharge or fluid running from ear ☐ Y ☐ N	____/____/____ DD MM YY	☐ Y ☐ N	____/____/____ DD MM YY

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

Symptom or Problem	When did it start?	Do you still have the symptom or problem?	When did it end?
Cough or choke □ Y □ N	_____/_____/_____ DD MM YY	□ Y □ N	_____/_____/_____ DD MM YY
Shortness of breath □ Y □ N	____/_____/_____ DD MM YY	□ Y □ N	____/_____/_____ DD MM YY
Nasal congestion or runny nose □ Y □ N	_____/_____/_____ DD MM YY	□ Y □ N	_____/_____/_____ DD MM YY
Throat irritation □ Y □ N	_____/_____/_____ DD MM YY	□ Y □ N	_____/_____/_____ DD MM YY
Other breathing-related symptoms (specify)_____ □ Y □ N	_____/_____/_____ DD MM YY	□ Y □ N	_____/_____/_____ DD MM YY

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

Wheezing □ Y □ N	_____/_____/_____ DD MM YY	□ Y □ N	_____/_____/_____ DD MM YY
Coughing □ Y □ N	____/_____/_____ DD MM YY	□ Y □ N	_____/_____/_____ DD MM YY
Trouble breathing □ Y □ N	_____/_____/_____ DD MM YY	□ Y □ N	_____/_____/_____ DD MM YY
Other asthma-related symptoms (specify)_____ □ Y	_____/_____/_____	□ 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 ☐ N	_____/_____/_____ DD MM YY	☐ Y ☐ N	_____/_____/_____ DD MM YY
Confusion ☐ Y ☐ N	_____/_____/_____ DD MM YY	☐ Y ☐ N	_____/_____/_____ DD MM YY
Dizziness ☐ Y ☐ N	_____/_____/_____ DD MM YY	☐ Y ☐ N	_____/_____/_____ DD MM YY
Lethargy ☐ Y ☐ N	_____/_____/_____ DD MM YY	☐ Y ☐ N	_____/_____/_____ DD MM YY
Loss of consciousness ☐ Y ☐ N	_____/_____/_____ DD MM YY	☐ Y ☐ N	_____/_____/_____ DD MM YY
Weakness ☐ Y ☐ N	_____/_____/_____ DD MM YY	☐ Y ☐ N	_____/_____/_____ DD MM YY
Seizures ☐ Y ☐ N	_____/_____/_____ DD MM YY	☐ Y ☐ N	_____/_____/_____ DD MM YY
Numbness ☐ Y ☐ N	_____/_____/_____ DD MM YY	☐ Y ☐ N	_____/_____/_____ DD MM YY
Tremor ☐ Y ☐ N	_____/_____/_____ DD MM YY	☐ Y ☐ N	_____/_____/_____ DD MM YY
Other nerve-related symptoms (specify) ☐ Y ☐ N	_____/_____/_____ DD MM YY	☐ Y ☐ N	_____/_____/_____ DD MM YY
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 □ N	____/____/____ DD MM YY	□ Y □ N	____/____/____ DD MM YY
Red skin □ Y □ N	____/____/____ DD MM YY	□ Y □ N	____/____/____ DD MM YY
Hives or welts □ Y □ N	____/____/____ DD MM YY	□ Y □ N	____/____/____ DD MM YY
Skin irritation/pain □ Y □ N	____/____/____ DD MM YY	□ Y □ N	____/____/____ DD MM YY
Rash (describe) _____ □ Y □ N	____/____/____ DD MM YY	□ Y □ N	____/____/____ DD MM YY
Infected cuts or scrapes □ Y □ N	____/____/____ DD MM YY	□ Y □ N	____/____/____ DD MM YY
Oher skin-related symptoms (specify) _____ □ Y □ N	____/____/____ DD MM YY	□ Y □ N	____/____/____ DD MM YY

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 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 going 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 pet's sickness?
No (SKIP TO 6P)
Yes 2
Don't know (SKIP TO 6P) 8
Refused (SKIP TO 6P) 9

5Pa. What was the diagnosis?

Describe: _____

What medications did your veterinarian 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, can you tell me what is wrong with it?

Describe: _____

Thank you.

Pulmonary function test results

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_1/FVC) in %	
Forced expiratory flow from 25% to 75% of vital capacity **(**$FEF_{25\%-75\%}$) 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?

- ☐ Red
- ☐ Brown
- ☐ Green
- ☐ Black
- ☐ Yellow
- ☐ White
- ☐ Not sure

Did you notice an unusual odor?

- ☐ Yes
- ☐ No
- ☐ 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 □ N	-------- am pm	□ Y □ N	--------- am pm
Chills □ Y □ N	-------- am pm	□ Y □ N	--------- am pm
Headache □ Y □ N	-------- am pm	□ Y □ N	--------- am pm
Sore throat □ Y □ N	-------- am pm	□ Y □ N	--------- am pm
Ear ache □ Y □ N	-------- am pm	□ Y □ N	--------- am pm
Discharge or fluid running from ear □ Y □ N	-------- am pm	□ Y □ N	--------- am pm
Abdominal pain □ Y □ N	-------- am pm	□ Y □ N	--------- am pm
Nausea □ Y □ N	-------- am pm	□ Y □ N	--------- am pm
Vomiting □ Y □ N	-------- am pm	□ Y □ N	--------- am pm
Diarrhea □ Y □ N	-------- am pm	□ Y □ N	--------- am pm
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 ☐ Y ☐ N	-------- am pm	☐ Y ☐ N	--------- am pm
Irritation or pain ☐ Y ☐ 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 □ N	-------- am pm	□ Y □ N	--------- am pm
Shortness of breath □ Y □ N	-------- am pm	□ Y □ N	--------- am pm
Nasal congestion or runny nose □ Y □ N	-------- am pm	□ Y □ N	--------- am pm
Throat irritation □ Y □ N	-------- am pm	□ Y □ N	--------- am pm
Other breathing-related symptoms (specify)_____ □ Y □ N	-------- am pm	□ Y □ N	--------- am pm

Asthma-related symptoms.

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

Nerve-related symptoms.

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

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

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

□ Yes
□ No

If someone did complain about symptoms, 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_1/FVC) in %	
Forced expiratory flow from 25% to 75% of vital capacity **(**$FEF_{25\%-75\%}$) 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.