Appendix C

Health screening questionnaire – field

Form Approved
OMB No. 0920-XXXX
Exp. Date xx/xx/20xx

INITIAL QUESTIONNAIRE – FIELD

UNIQUE ID:

DEMOGRAPHICS

Sex

O Male **O** Female

Race/Ethnicity

O White	**O** Black
O Asian	**O** American Indian or Alaska Native
O Native Hawaiian or Other Pacific Islander	**O** Hispanic or Latino
O Other Race	

Education

What is the highest grade or year of school you completed?

O Never attended school or only kindergarten	**O** Grades 1 through 8 (Elementary)
O Grades 9 through 11 (Some high school)	**O** Grades 12 or GED (High school graduate)
O College 1 year to 3 years (Some college or technical school)	**O** College 4 years or more (College graduate)

Age

What is your age? _____

CDC estimates the average public reporting burden for this collection of information as 30 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-XXXX).

CHRONIC DISEASE

Has a doctor, nurse, or other health professional ever told you that you had any of the following?

Angina or coronary heart disease **O** Yes **O** No	Any type of cancer? **O** Yes **O** No List_____
Heart attack (also called myocardial infarction) **O** Yes **O** No	Skin disorder? **O** Yes **O** No List _____
Stroke **O** Yes **O** No	Diabetes **O** Yes **O** No
TIA (transient ischemic attack) **O** Yes **O** No	Kidney disease (do not include kidney stones, bladder infections, or incontinence) **O** Yes **O** No
Heart failure **O** Yes **O** No	Kidney stones **O** Yes **O** No
Atrial fibrillation **O** Yes **O** No	Bladder infections **O** Yes **O** No
Other irregular heart beat that requires medical management (e.g. arrhythmia) **O** Yes **O** No	Sleep apnea **O** Yes **O** No
Valvular heart disease **O** Yes **O** No	High blood pressure **O** Yes **O** No
Known heart murmur **O** Yes **O** No	High cholesterol **O** Yes **O** No
Peripheral artery disease **O** Yes **O** No	Hernia **O** Yes **O** No
Seizures **O** Yes **O** No	Tremors **O** Yes **O** No
Asthma **O** Yes **O** No	Neurological disorders **O** Yes **O** No List _____
COPD, emphysema, or chronic bronchitis **O** Yes **O** No	Hyperthyroidism **O** Yes **O** No
Other lung disease? **O** Yes **O** No List_____	

Symptoms		
In the past month, have you had any difficulty or pain with swallowing food or liquids?	**O** Yes	**O** No
Do you have any disorders of the esophagus?	**O** Yes	**O** No
Do you have known or suspected obstructive disease or hypomotility disorders of the gastrointestinal tract (e.g. diverticulitis, inflammatory bowel disease, ileus, but NOT irritable bowel disorder)?	**O** Yes	**O** No
Do you have problems swallowing?	**O** Yes	**O** No
Do you have a cardiac pacemaker or implantable cardioverter defibrillator?	**O** Yes	**O** No
Have you previously had gastrointestinal surgery?	**O** Yes	**O** No

Other
Do you smoke cigarettes? **O** Yes **O** No If yes, _____ (number) cigarettes _____ (how often)
Women only: Are you (or could you be) pregnant? **O** Yes **O** No

MEDICATIONS

Please indicate whether you are currently taking any medications within the following medication categories:

Diuretics **O** Yes **O** No	Antihistamines (prescription or over-the-counter, e.g. Benadryl, Claritin, Allegra) **O** Yes **O** No
Blood pressure medications (beta blockers, angiotensin receptor blockers, ACE inhibitors, calcium channel blockers) other than diuretics **O** Yes **O** No	Decongestants (e.g. Sudafed) **O** Yes **O** No
Depression medications **O** Yes **O** No	Prescription pain medications **O** Yes **O** No
Other psychiatric medications **O** Yes **O** No	Sedatives **O** Yes **O** No

List any other medications (including over-the-counter products) that you are currently taking.

_____

_____

_____

HEAT ILLNESS/CONDITION AND TRAINING

Have you ever had the following illnesses related to heat?

Heat Condition	Have you had this condition?	Number of work days lost, if any	Number of days it interfered with your day-to-day responsibilities (at work and home), if any
Heat stroke	**O** Yes **O** No		
Heat exhaustion	**O** Yes **O** No		
Heat cramps	**O** Yes **O** No		
Heat-related fainting	**O** Yes **O** No		
Heat rash	**O** Yes **O** No		

Have you received training on how to prevent heat-related illness? **O** Yes **O** No

Please rate how much you agree or disagree with the following statements:

My job duties often interfere with taking precautions against heat-related illness (i.e., taking breaks, drinking fluids, etc.)

O Strongly agree **O** Agree **O** Undecided **O** Disagree **O** Strongly disagree

Workers are expected (by peers, supervisors, or themselves) to work through hot conditions, even if they don't feel well.

O Strongly agree **O** Agree **O** Undecided **O** Disagree **O** Strongly disagree

Over the past 6 months, have you had any of the following symptoms at work?

O Nausea
O Dizziness/ Lightheadedness
O Headache
O Irritability
O Profuse sweating
O Vomiting
O Muscle weakness
O Confusion
O Excessive fatigue
O Excessive thirst that was not easily quenched
O Muscle cramps or spasms
O Decreased urine output or dark colored urine

PHYSICAL FITNESS

Circle one number below that best describes your overall level of physical activity for the previous 6 months.

1	Avoids walking or exertion (for example, always uses elevators, drives when possible instead of walking).
2	Light activity: Walks for pleasure, routinely uses stairs, occasionally exercises sufficiently to cause heavy breathing or perspiration.
3	10–60 minutes per week of recreation requiring modest physical activity (such as golf, bowling, weight lifting, or yard work).
4	Over 1 hour per week of recreation requiring modest physical activity (such as golf, bowling, weight lifting, or yard work).
5	Runs less than 1 mile per week or spends less than 30 minutes per week in comparable heavy physical activity (such as swimming, tennis, or basketball).
6	Runs 1–5 miles per week or spends 30–60 minutes per week in comparable heavy physical activity (such as swimming, tennis, or basketball).
7	Runs 5–10 miles per week or spends 1–3 hours per week in comparable heavy physical activity (such as swimming, tennis, or basketball).
8	Runs more than 10 miles per week or spends more than 3 hours per week in comparable heavy physical activity (such as swimming, tennis, or basketball).

Describe the percentage of time that your physical activity at work is very light, light, moderate, and heavy.

Very light _____%
Light _____%
Moderate _____%
Heavy _____%

CURRENT WORK

How long have you worked in mining?

_____ **O** Months or **O** Years

How long have you worked at your mine?

_____ **O** Months or **O** Years

How long have you worked at your current position or job?

_____ **O** Months or **O** Years

What is your current position or job title?

_____

Please list your most common job activities: _____

_____

_____

Which of the following best describes the hours you usually work?

O Regular daytime schedule

O Regular evening shift: anytime between 2pm and midnight

O Regular night shift: anytime between 9pm and 8am

O Forward rotating shift: changes from days to evenings to nights

O Backward rotating shift: changes from nights to evenings to days

O Other (please explain)

_____

_____

How long are your shifts?	
O 8 hours	**O** 10 hours
O 12 hours	**O** Other (please explain) _____ _____
O Variable (please explain) _____ _____	

WORK CONDITIONS

Do the environmental conditions (e.g., level of heat and humidity) of your work change with the season? **O** Yes **O** No

If YES, answer the following questions:

In general during the warm season, how would you describe the air temperature at your work area? **O** Cold **O** Cool **O** Neutral **O** Slightly warm **O** Warm **O** Hot **O** Very hot

In general during the warm season, how would you describe the humidity at your work area? **O** Dry **O** Neutral **O** Humid

In general during the warm season, how is the air circulation or breeze in your workplace? **O** Cold air flow/breeze **O** Cool air flow/breeze **O** No air flow/breeze **O** Warm air flow/breeze **O** Hot air flow/breeze

In general during the warm season, how much do you sweat at work? **O** I do not sweat **O** I sweat a little (i.e. armpits, face) **O** I sweat a moderate amount (i.e. armpits, face, chest, back) **O** I sweat a lot (i.e. clothes get completely wet)

In general during the warm season, how physically fatigued are you at the end of your work day? **O** Not tired at all **O** A little tired **O** Tired **O** Extremely tired

In general during the warm season, how thirsty do you get at work? **O** Not thirsty at all **O** I get thirsty occasionally **O** I get thirsty frequently **O** I am thirsty all the time

In general during the warm season, how hot do you get in your work area? **O** Not hot at all **O** A little warm **O** Warm **O** Hot **O** Very hot

In the last 30 days, have you worked at least 5 consecutive days in an area that you felt was warm or hot? **O** Yes **O** No

If NO, answer the following questions:

In general during the past month, how would you describe the air temperature at your work area? **O** Cold **O** Cool **O** Neutral **O** Slightly warm **O** Warm **O** Hot **O** Very hot

In general during the past month, how would you describe the humidity at your work area? **O** Dry **O** Neutral **O** Humid

In general during the past month, how is the air circulation or breeze in your work area? **O** Cold air flow/breeze **O** Cool air flow/breeze **O** No air flow/breeze **O** Warm air flow/breeze **O** Hot air flow/breeze

In general during the past month, how much do you sweat at work? **O** I do not sweat **O** I sweat a little (i.e. armpits, face) **O** I sweat a moderate amount (armpits, face, chest, back) **O** I sweat a lot (clothes get completely wet)

In general over the past month, how physically fatigued are you at the end of your work day? **O** Not tired at all **O** A little tired **O** Tired **O** Extremely tired

In general over the past month, how thirsty do you get at work? **O** Not thirsty at all **O** I get thirsty occasionally **O** I get thirsty frequently **O** I am thirsty all the time

In general over the past month, how hot do you get in your work area? **O** Not hot at all **O** A little warm **O** Warm **O** Hot **O** Very hot

In the past month, have you worked at least 5 consecutive days in an area that you felt was warm or hot? **O** Yes **O** No

MENTAL HEALTH

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
Feeling down, depressed, or hopeless				
Little interest or pleasure in doing things				

NIOSH USE ONLY

Height _____ Weight _____ lbs Body fat %_____