**Attachment 3**

**Questionnaire**

Form Approved

OMB NO. 0920-xxxx

Expiration Date: xx/xx/20xx

ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NORA\_FY2019  
Styrene-Exposed Cohort**

**NIOSH-Administered Former Employee Health Questionnaire**

Interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interview Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Day) (Year)

**Section I: Identification and Demographic Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

(Last Name) (First Name) (M.I.)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Number, Street, and/or Rural Route)

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

(City) (State) (Zip Code)

Primary Telephone Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_\_ [ ] Home [ ] Cell

***If you were to move, is there someone who would know how to contact you?***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

(Last Name) (First Name) (M.I.)

Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Number, Street, and/or Rural Route)

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

(City) (State) (Zip Code)

Primary Telephone Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_\_ [ ] Home [ ] Cell

Public reporting burden of this collection of information is estimated to average 45 mins 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxx).

1. Date of Birth: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Day) (Year)

1. Sex: 1. \_\_\_\_ Male 0. \_\_\_\_Female
2. Are you Spanish, Hispanic or Latino? 1. \_\_\_\_ Yes 0. \_\_\_\_No
3. Select one or more of the following categories

to describe your race: 1.\_\_\_ American Indian or Alaska Native

2.\_\_\_ Asian

3.\_\_\_ African-American or Black

4.\_\_\_ Native Hawaiian or Other Pacific Islander

5.\_\_\_ White

**Section II: Health Information**

**I’m going to ask you some questions about your health. The answer to many of these questions will be “Yes” or “No.” If you are in doubt about whether to answer “Yes” or “No,” then please answer “No.”**

1. During the past 12 months, have you had any trouble

with your breathing? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. Which of the following statements best describes

your breathing?

1.\_\_\_ I only rarely have trouble with my breathing.

2.\_\_\_ I have regular trouble with my breathing, but it always gets completely better.

3. \_\_\_ My breathing is never quite right.

* 1. In what month and year did the trouble with your

breathing first begin? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

1. Are you troubled by shortness of breath when hurrying on

level ground or walking up a slight hill? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. Do you get short of breath walking with other people of

your own age on level ground? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

* 1. Do you ever have to stop for breath when walking

at your own pace on level ground? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

* 1. Do you ever have to stop for breath after walking about

100 yards (or after few minutes) on level ground? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. Do you usually have a cough?

*(Count cough with first smoke or on first going* 1.\_\_\_\_ Yes 0. \_\_\_\_ No

*out-of-doors. Exclude clearing of throat.)*

**IF YES:**

* 1. Do you usually cough on most days for 3  
     consecutive months or more during the year? 1.\_\_\_\_ Yes 0. \_\_\_\_ No
  2. In what month and year did this cough first begin? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

1. Do you bring up phlegm on most days for 3

consecutive months or more during the year? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. Have you had wheezing or whistling in your chest at

anytime in the last 12 months? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. In what month and year did this wheezing or

whistling first begin? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

1. Have you woken up with a feeling of tightness in your

chest at any time in the last 12 months? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. In what month and year did this chest tightness

first begin? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

1. Have you been woken by an attack of coughing

at any time in the last 12 months? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. In what month and year did these attacks of

coughing first begin? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

1. Have you had an attack of asthma in the last 12 months? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. In what month and year did these attacks of asthma

first begin? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

1. Are you currently taking any medicine including inhalers,

aerosols or tablets, for asthma? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. In what month and year did you first begin using

medicine for asthma? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

1. Are you currently taking any medicine including inhalers,

aerosols or tablets, for any other breathing problems? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. In what month and year did you first begin using

medicine for any other breathing problems? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

1. Have you **ever** been told by a physician that you had any of the following respiratory conditions?

|  |  |  |
| --- | --- | --- |
| Conditions | Told by a physician you had? | Month and Year of first diagnosis? |
| 1. Hay fever or nasal allergies | 1. Yes \_\_\_  0. No \_\_\_ |  |
| 2. Sinusitis or sinus infections | 1. Yes \_\_\_  0. No \_\_\_ |  |
| 3. Chronic bronchitis | 1. Yes \_\_\_  0. No \_\_\_ |  |
| 4. Emphysema | 1. Yes \_\_\_  0. No \_\_\_ |  |
| 5. Chronic obstructive pulmonary disease (COPD) | 1. Yes \_\_\_  0. No \_\_\_ |  |
| 6. Obliterative bronchiolitis | 1. Yes \_\_\_  0. No \_\_\_ |  |
| 7. Asthma | 1. Yes \_\_\_  0. No \_\_\_ |  |
| 7.1 **IF YES**:  Do you still have asthma? | 1. Yes \_\_\_  0. No \_\_\_ |  |

1. Have you **ever** been told by a physician that you had

any other respiratory condition? 1.\_\_\_\_ Yes 0.\_\_\_\_ No

**IF YES:**

* 1. What was the diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  2. In what month and year were you first given this

diagnosis? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

1. Have you ever had a lung biopsy? 1.\_\_\_\_ Yes 0.\_\_\_\_ No

**IF YES:**

* 1. What was the diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  2. In what month and year was the biopsy taken? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

* 1. What was the name of the hospital or health care facility where the biopsy was taken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Now I am going to ask you about other health problems. Have you **ever** been told by a physician that you had any of the following conditions?

|  |  |  |
| --- | --- | --- |
| Conditions | Told by a physician you had? | Month and Year of first diagnosis? |
| 1. Hearing loss | 1. Yes \_\_\_  0. No \_\_\_ |  |
| 2. Cancer | 1. Yes \_\_\_  0. No \_\_\_ |  |
| 2.1 **IF YES:**  What type of cancer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**Section III. Boatbuilding Work Information**

**I’m now going to ask you about your time working in the boatbuilding industry.**

1. Where did you work? 1. \_\_\_\_Uniflite, Bellingham, WA

2. \_\_\_\_Tollycraft, Kelso, WA

3. \_\_\_\_Both

1. I’m now going to ask you to list all of the jobs that you have had while working at Uniflite or Tollycraft. What was the first job you held at Uniflite or Tollycraft?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| Job # | Department | Job Performed | Start Date  (mm/yyyy) | End Date  (mm/yyyy) | Average Hours/Week |  |
|  | (Drop Down menus populated with lists)   1. Fibrous glass 2. Lamination 3. Boat Assembling 4. Administrative 5. General Plant-wide department 6. Don’t remember | (Drop Down menus populated with lists)   1. Hull lamination 2. Deck lamination 3. Small parts lamination 4. Gel coat 5. Mold repair & patch 6. Model development 7. Stringer installation 8. Overlay & patch 9. Assembly worker 10. Manager 11. Secretory 12. Administrative assistant 13. Security 14. Maintenance 15. Janitorial 16. Upholsterer 17. General laborer 18. Foreman |  |  |  | Did you wear breathing protection while at work?   1. Always 2. Sometimes 3. Rarely 4. Never 5. Don’t remember |

**Section IV. Other Work Information**

**I’m now going to ask you about all the jobs you have worked since leaving Uniflite or Tollycraft. We will start with your most recent job and work back through time.**

1. List all jobs that you had in any other boatbuilding facility since leaving Uniflite or Tollycraft.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
| Job # | Company name | Location | Department | Job performed | Start date  (MM/YYYY) | End Date  (MM/YYYY) | Average Hours/Week |
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1. List all other jobs NOT in boatbuilding that you had since leaving Uniflite or Tollycraft.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |
| Job # | Company name | Location | Job title | Start date  (MM/YYYY) | End Date  (MM/YYYY) | Avg.  Hours/week | Primary task | Other task | Styrene or styrene containing products |
|  |  |  |  |  |  |  |  |  |  |
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**Section V: Tobacco and Marijuana Use Information**

**I’m now going to ask you a few questions about smoking**.

1. Have you ever smoked cigarettes? 1. \_\_\_ Yes 0. \_\_\_ No

(*NO if less than 20 packs of cigarettes in*

*a lifetime or less than 1 cigarette a day for 1 year*)

**IF YES:**

* 1. How old were you when you first started

smoking regularly? \_\_\_\_\_\_ Years old

* 1. Over the entire time that you have smoked,

what is the average number of cigarettes

you smoked per day? \_\_\_\_\_\_ Cigarettes/day

* 1. Do you still smoke cigarettes? 1. \_\_\_ Yes 0. \_\_\_ No

**IF NO:**

23.3.1. How old were you when you stopped

smoking cigarettes regularly? \_\_\_\_\_\_ Years old

**I’m now going to ask you a few questions about smoking marijuana.**

1. During your life, have you smoked marijuana more than 50 times? 1. \_\_\_ Yes 0.\_\_\_ No

**IF Yes:**

* 1. Have you smoked marijuana in the past 12 months? 1.\_\_\_Yes 0.\_\_\_No

**IF Yes:**

24.2.1. Have you smoked marijuana in the past 30 days? 1.\_\_\_Yes 0.\_\_\_No

**Thank you for participating in this survey!**