

Attachment 7

Symptom Survey

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: _____

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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 <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Chills <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Headache <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Sore throat <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Ear ache <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Discharge or fluid running from ear <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> 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 <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Nausea <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Diarrhea with blood <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Other general symptoms or problems (specify) _____ <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Blurred Vision <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Irritation or pain <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Redness or discharge from eyes <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Conjunctivitis (Pink eye) <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Other eye problems (specify) _____ <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> 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 <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Shortness of breath <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Nasal congestion or runny nose <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Throat irritation <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Other breathing-related symptoms (specify) _____ <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| <p>Asthma-related symptoms: Just as a reminder for me, has a doctor, nurse, or other health professional ever told you that you had asthma?</p> <p>No (SKIP TO next section)</p> <p>Yes 2</p> <p>Don't know (SKIP TO NEXT SECTION) 8</p> <p>Refused (SKIP TO NEXT SECTION) 9</p> | | | |
| Wheezing <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Coughing <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Trouble breathing <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Other asthma-related symptoms (specify) _____ <input type="checkbox"/> Y | ____/____/____ | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |

| Symptom or Problem | When did it start? | Do you still have the symptom or problem? | When did it end? |
|--|-------------------------|--|-------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | DD MM YY | | |
| Nerve-related symptoms. | | | |
| Agitation <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY |
| Confusion <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY |
| Dizziness <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY |
| Lethargy <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY |
| Loss of consciousness <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY |
| Weakness <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY |
| Seizures <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY |
| Numbness <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY |
| Tremor <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY |
| Other nerve-related symptoms (specify) <input type="checkbox"/> Y <input type="checkbox"/> N | ___/___/___ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> 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 <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Red skin <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Hives or welts <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Skin irritation/pain <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Rash (describe) _____ <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Infected cuts or scrapes <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY |
| Other skin-related symptoms (specify) _____ <input type="checkbox"/> Y <input type="checkbox"/> N | ____/____/____ DD MM YY | <input type="checkbox"/> Y <input type="checkbox"/> 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 <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Chills <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Headache <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Sore throat <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Ear ache <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Discharge or fluid running from ear <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Abdominal pain <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Nausea <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Diarrhea with blood | | <input type="checkbox"/> Y | |

| Symptom or Problem | When did it start? | Do you still have the symptom or problem? | When did it end? |
|--|--------------------|--|------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Other general symptoms or problems (specify) _____ <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Eye-related symptoms | | | |
| Blurred Vision <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Irritation or pain <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Redness or discharge from eyes <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Conjunctivitis (Pink eye) <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Other eye problems (specify) _____ <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> 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 <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Shortness of breath <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Nasal congestion or runny nose <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Throat irritation <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Other breathing-related symptoms (specify) _____ <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |

Asthma-related symptoms.

| | | | |
|---|-------------|--|-------------|
| Wheezing <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Coughing <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Trouble breathing <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Other asthma-related symptoms (specify) _____ <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |

Nerve-related symptoms.

| | | | |
|---|-------------|--|-------------|
| Agitation <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Confusion <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Dizziness <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Lethargy <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Loss of consciousness <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Weakness <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Seizures <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Numbness <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Tremor <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Other nerve-related symptoms (specify) <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |

| | | | |
|--|-------------|--|-------------|
| Itchy skin <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Red skin <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Hives or welts <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Skin irritation/pain <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Rash (describe) _____ <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Infected cuts or scrapes <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm |
| Other skin-related symptoms (specify) _____ <input type="checkbox"/> Y <input type="checkbox"/> N | ----- am pm | <input type="checkbox"/> Y <input type="checkbox"/> 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.