# Baseline Questionnaire

Form Approved

OMB No. XXX

Exp. Date XX/XX/XXXX

**Date:** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ **Unique ID:** \_\_\_\_\_\_\_\_\_\_

(Month) (Day) (Year) (assigned by study personnel)

**Section I: Screening**

1. Have you worked at a clinical veterinary practice in any position

(including, but limited to, veterinarian; veterinary technologist,

nurse, technician, or assistant; kennel staff; grooming staff; office staff;

or environmental services staff) at any time during the past 12 months? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES: CONTINUE**

**IF NO: STOP**

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

(data collection system to calculate age) (Month) (Day) (Year)

**IF >=18 years old: CONTINUE**

**IF <18 years old: STOP**

**Section II: Demographic Information**

1. What is your race and/or ethnicity? One or more

categories may be selected. 1.\_\_\_ American Indian or Alaska Native

*For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.*

2.\_\_\_ Asian

*For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.*

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

*For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.*

4.\_\_\_ Hispanic or Latino

*For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.*

5.\_\_\_ Middle Eastern or North African

For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.

6.\_\_\_ Native Hawaiian or Pacific Islander

For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.

7.\_\_\_ White

For example, English, German, Irish, Italian, Polish, Scottish, etc.

1. What is your current gender? One or more categories

may be selected. 1.\_\_\_ Female

2.\_\_\_ Male

3.\_\_\_ Transgender

4.\_\_\_ [If respondent marked AIAN] Two-Spirit

5.\_\_\_ I use a different term

**IF I USE A DIFFERENT TERM:**

* 1. Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. What sex were you assigned at birth, on your original birth

certificate? 1.\_\_\_\_ Male 0. \_\_\_\_Female

1. What is the highest grade or level of school you have

completed or the highest degree received? 1.\_\_\_\_ 8th grade or less

2.\_\_\_\_ 9th-12th grade (no diploma)

3.\_\_\_\_ High school graduate (diploma)

4.\_\_\_\_ GED or equivalent

5.\_\_\_\_ Some college (no degree)

6.\_\_\_\_ Associate’s degree: occupational, technical, or vocational program

7.\_\_\_\_ Associate’s degree: academic (general education)

8.\_\_\_\_ Bachelor’s degree (example: BA, AB, BS, BBA)

9.\_\_\_\_ Master’s degree (example: MA, MS, MEng, Med, MBA)

10.\_\_\_ Professional school degree (example: MD, DDS, DVM, JD)

11.\_\_\_ Doctoral degree (example: PhD, EdD)

**Section III: Current Health Information**

**The next set of questions are 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. When you are away from clinical veterinary practice on days

off or on vacation, is the trouble with your breathing: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. During the past 4 weeks, have you had any trouble

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

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 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 a few minutes) on level ground? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

* 1. In what month and year did your breathlessness start? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

1. Do you usually have a cough? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

*(Count cough with first smoke or on first going 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

* 1. In what month and year did this cough begin? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

* 1. When you are away from clinical veterinary practice on days

off or on vacation, is your cough: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates this cough? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you had a cough at any time in the last 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

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

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

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, is this wheezing or whistling: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates this wheezing or whistling? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you had wheezing or whistling in your chest

at any time in the last 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

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. When you are away from clinical veterinary practice on days

off or on vacation, is this chest tightness: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates this chest tightness? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you woken up with a feeling of tightness in

your chest at any time in the last 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. Have you been woken by an attack of shortness of breath at

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

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, are these attacks of shortness of breath: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates these attacks of shortness of breath? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you been woken by an attack of shortness of

breath at any time in the last 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

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

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, are these attacks of asthma: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates these attacks of asthma? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you had an attack of asthma in the last 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. Are you currently taking any medicine including inhalers,

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

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, do you take the medicine for asthma: 1.\_\_\_ The same

2.\_\_\_ More Often

3.\_\_\_ Less Often

1. Are you currently taking any medicine including inhalers,

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

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, do you take the medicine for other

breathing problems: 1.\_\_\_ The same

2.\_\_\_ More Often

3.\_\_\_ Less Often

1. During the past 12 months, have you had episodes of a

stuffy, itchy, or runny nose? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, are these nose symptoms: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates these nose symptoms? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you had episodes of a stuffy, itchy,

or runny nose in the past 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. During the past 12 months, have you had episodes of a

stinging or burning nose? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, are these nose symptoms: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates these nose symptoms? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you had episodes of a stinging or burning

nose in the past 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. During the past 12 months, have you had a problem with sneezing,

or a runny, or blocked nose when you did not have a cold or the flu? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, are these nose symptoms: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates these nose symptoms? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you had a problem with sneezing, or a runny, or

blocked nose when you did not have a cold or the flu in

the past 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. During the past 12 months, have you had sinusitis

or sinus problems? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, are these sinus problems: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates these sinus problems? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you had sinusitis or sinus problems

in the past 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. During the past 12 months, have you had hoarseness or a dry, sore,

or burning throat? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, are these throat symptoms: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates these throat symptoms? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you had hoarseness or a dry, sore, or burning throat

in the past 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. During the past 12 months, have you had episodes of

watery, itchy eyes? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, are these eye symptoms: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates these eye symptoms? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you had episodes of watery, itchy

eyes in the past 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. During the past 12 months, have you had episodes of

stinging or burning eyes? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, are these eye symptoms: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates these eye symptoms? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you had episodes of stinging or burning

eyes in the past 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. During the past 12 months, have you had frequent or severe

headaches, including migraines? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, are these headaches: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates these headaches? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you had frequent or severe headaches, including

migraines, in the past 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. During the past 12 months, have you had episodes of fever,

chills, or flu-like achiness? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. When you are away from clinical veterinary practice on days

off or on vacation, are these episodes of fever, chills, or

flu-like achiness: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

* 1. Is there anything at the clinical veterinary practice that causes or

aggravates these episodes of fever, chills, or

flu-like achiness? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* + 1. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you had episodes of fever, chills, or flu-like

achiness in the past 4 weeks? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. Have you **ever** been told by a physician or other health professional that you had any of the following conditions? **(Select all that apply.)**

|  |  |  |
| --- | --- | --- |
| **Conditions** | **Month and year of**  **first diagnosis?** | **Thought to be**  **work-related?** |
| 1. \_\_\_\_ Hay fever or nasal allergies | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 2. \_\_\_\_ Animal-related allergies | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 3. \_\_\_\_ Eczema, dermatitis, or skin allergy | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 4. \_\_\_\_ Heart disease | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 5. \_\_\_\_ Gastroesophageal reflux disease (GERD) | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 6. \_\_\_\_ Sinusitis or sinus infections | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 7. \_\_\_\_ Chronic bronchitis | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 8. \_\_\_\_ Emphysema | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 9. \_\_\_\_ Chronic obstructive pulmonary disease (COPD) | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 10. \_\_\_\_ Hypersensitivity pneumonitis | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 11. \_\_\_\_ Chemical pneumonitis | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 12. \_\_\_\_ Sarcoidosis | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 13. \_\_\_\_ Interstitial lung disease | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 14. \_\_\_\_ Asthma | \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| **IF YES**:  14.1 Do you still have asthma? | 1.\_\_\_\_ Yes 0. \_\_\_\_ No | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |
| 15. \_\_\_\_ Cancer | 1.\_\_\_\_ Yes 0. \_\_\_\_ No |  |
| **IF YES**:  15.1 What type of cancer(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  15.2 Month and year of first diagnosis(es)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

1. Have you **ever** been told by a physician or other health

professional that you had any other **respiratory** condition

(infectious **or** non-infectious)? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

(online questionnaire to allow multiple entries)

* 1. What was the diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  2. Was this condition suspected to be work-related? 1.\_\_\_\_ Yes 0. \_\_\_\_ No
  3. In what month and year were you first given this

**respiratory** condition diagnosis? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

**IF YES to QUESTION #14 (attack of asthma in the last 12 months) or QUESTION #26.14 (Asthma):**

1. Since you began working in a veterinary clinic setting,

is your asthma: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

1. Have you **ever** had to change your veterinary work duties

because of your asthma? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF YES to QUESTION #26.1 (Hay fever or nasal allergies) or QUESTION #26.2 (Animal-related allergies):**

1. Since you began working in a veterinary clinic setting,

are your allergies: 1.\_\_\_ The same

2.\_\_\_ Worse

3.\_\_\_ Better

1. Have you **ever** had to change your veterinary work duties

because of your allergies? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section IV. Tasks and Related Potential Hazards**

**The next set of questions are about tasks and related potential hazards at work.**

1. During an average work week, are you exposed to surgical smoke

generated during electrosurgery (including electrocautery,

diathermy, and ultrasonic devices)? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. When was the last time you received training that addresses

the hazards of surgical smoke? 1.\_\_\_\_ Within the past 12 months

2.\_\_\_\_ More than 12 months ago

3.\_\_\_\_ I never received training

* 1. Does your employer have standard procedures that

address potential hazards of surgical smoke? 1.\_\_\_ Yes 0. \_\_\_ No 2. \_\_\_ Don’t Know

* 1. At any time in the past 7 calendar days, did you work within

5 feet of the source of surgical smoke during electrosurgery?

(Electrosurgery includes electrocautery, diathermy, and

ultrasonic devices.) 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

**Local Exhaust Ventilation (LEV) captures and removes contaminants at the point where they are being produced, such as a portable exhaust system with high efficiency particulate filters, or a flexible tube connected to a room (wall) suction system. LEV does not include blood suction canister systems.**

**Electrosurgery includes electrocautery, diathermy, and ultrasonic devices.**

* + 1. During the past 7 calendar days, how often was LEV

(e.g., portable smoke evacuator or room [wall] suction

system) used while you worked within 5 feet of the

source of surgical smoke during electrosurgery? 1.\_\_\_\_ Always

2.\_\_\_\_ Sometimes

3.\_\_\_\_ Never

**IF ALWAYS OR SOMETIMES:**

* + - 1. During the past 7 calendar days, what type

of LEV was used while you worked within

5 feet of the source of surgical smoke

during electrosurgery?

**(Select all that apply)** 1.\_\_\_\_ Portable smoke evacuator

2.\_\_\_\_ Room (wall) suction system

**IF SOMETIMES OR NEVER:**

* + - 1. What was the reason(s) LEV was not

always used during electrosurgery?

**(Select all that apply)** 1.\_\_\_\_ General room ventilation was sufficient to dissipate smoke plume

2.\_\_\_\_ Used a different system (e.g., blood suction canister) to remove the smoke

3.\_\_\_\_ Exposure was minimal

4.\_\_\_\_ Not part of our protocol

5.\_\_\_\_ Not provided by employer

6.\_\_\_\_ No one else who does this work uses them

7.\_\_\_\_ Too difficult to use

8.\_\_\_\_ Too bulky or noisy

9.\_\_\_\_ Not readily available in work area

10.\_\_\_ Not permitted by surgeon

11.\_\_\_ Other (specify)

**IF MORE THAN ONE REASON CHECKED:**

* + - * 1. Of the reasons you checked

above, please indicate the most

important reason local exhaust

ventilation was not always

used. **(Select one)** 1.\_\_\_\_ General room ventilation was sufficient to dissipate smoke plume

2.\_\_\_\_ Used a different system (e.g., blood suction canister) to remove the smoke

3.\_\_\_\_ Exposure was minimal

4.\_\_\_\_ Not part of our protocol

5.\_\_\_\_ Not provided by employer

6.\_\_\_\_ No one else who does this work uses them

7.\_\_\_\_ Too difficult to use

8.\_\_\_\_ Too bulky or noisy

9.\_\_\_\_ Not readily available in work area

10.\_\_\_ Not permitted by surgeon

11.\_\_\_ Other (specify)

1. Do you perform mask or chamber induction using an inhalational

anesthetic (e.g., Sevoflurane or Isoflurane)? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. Do you work with animals that are under general

anesthesia, or recovering from general anesthesia, using an

inhalational anesthetic (e.g., Sevoflurane or Isoflurane) 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. How often do you detect the odor of an inhalational anesthetic? 1.\_\_\_\_ Never

2.\_\_\_\_ Sometimes

3.\_\_\_\_ Frequently

1. Is there a waste anesthetic gas scavenging system

at the clinical veterinary practice? 1.\_\_\_ Yes 0. \_\_\_ No 2. \_\_\_ Don’t Know

**IF YES:**

* 1. When is the waste anesthetic gas scavenging

system checked for proper functioning? 1.\_\_\_\_ Before each anesthetic procedure

2.\_\_\_\_ Before starting anesthetic procedures each day

3.\_\_\_\_ Daily, but not necessarily before starting anesthetic procedures each day

4.\_\_\_\_ Weekly

5.\_\_\_\_ Don’t know

6.\_\_\_\_ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Is there a waste anesthetic gas scavenging

system preventive maintenance program? 1.\_\_\_ Yes 0. \_\_\_ No 2. \_\_\_ Don’t Know

**IF YES:**

* + 1. Who performs the preventive

maintenance? **(Select all that apply.)** 1.\_\_\_\_ Contractor

2. \_\_\_\_ Myself

3. \_\_\_\_ Lead technician

4. \_\_\_\_ Chief of staff (veterinarian)

5. \_\_\_\_ Any staff veterinarian

6. \_\_\_\_ Office manager

7. \_\_\_\_ Don’t know

8.\_\_\_\_ Other (specify):\_\_\_\_\_\_\_\_\_\_\_

1. During an average work week, do you use cleaning, disinfecting,

or sterilizing agents at your veterinary clinic? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. Do you clean, disinfect, or sterilize any of the

following at your veterinary clinic?

**(Select all that apply.)** 1.\_\_\_\_ Animal cages, kennels, or runs

2.\_\_\_\_ Litter boxes

3.\_\_\_\_ Bird cages

4.\_\_\_\_ Barn stalls

5.\_\_\_\_ Other area(s) containing animal wastes (specify)

6.\_\_\_\_ Medical equipment/instruments

7.\_\_\_\_ Surfaces, such as examination tables, surgery tables, and counters

**FOR EACH SELECTED:**

* + 1. What cleaning product(s) do you use most often

when performing this cleaning, disinfecting, or

sterilizing? (Brand names or chemical names

are acceptable.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. During an average workday, do you breathe in motor

vehicle exhaust? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. Do you perform any other task(s) at your veterinary clinic

that you feel expose you to respiratory hazards? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. Describe the task(s) and respiratory hazard(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section V. Personal Protective Equipment**

**The next set of questions are about personal protective equipment (PPE) use.**

**IF QUESTION #32.3 is YES (any time in the past 7 calendar days worked within 5 feet of the source of surgical smoke during electrosurgery):**

1. During the past 7 calendar days, how often did you wear

protective gloves during electrosurgery? 1.\_\_\_\_ Always

2.\_\_\_\_ Sometimes

3.\_\_\_\_ Never

1. During the past 7 calendar days, how often did you wear eye

protection while you worked within 5 feet of the source of

surgical smoke during electrosurgery? Examples of eye

protection include goggles and safety glasses. Do not include

personal eye glasses. 1.\_\_\_\_ Always

2.\_\_\_\_ Sometimes

3.\_\_\_\_ Never

**IF SOMETIMES OR NEVER:**

* 1. What are the reason(s) you did not always wear eye

protection during electrosurgery? **(Select all that apply)** 1.\_\_\_\_ An engineering control (e.g., local exhaust ventilation) was being used

2.\_\_\_\_ Exposure was minimal

3.\_\_\_\_ Not part of our protocol

4.\_\_\_\_ Not provided by employer

5.\_\_\_\_ No one else who does this work uses them

6.\_\_\_\_ Too uncomfortable or difficult to use

7.\_\_\_\_ Not readily available in work area

8.\_\_\_\_ Other (specify)

**IF MORE THAN ONE REASON CHECKED:**

* + 1. Of the reasons you selected, please indicate the

most important reason you did not always wear

eye protection during electrosurgery. **(Select one)** 1.\_\_\_\_ An engineering control (e.g., local exhaust ventilation) was being used

2.\_\_\_\_ Exposure was minimal

3.\_\_\_\_ Not part of our protocol

4.\_\_\_\_ Not provided by employer

5.\_\_\_\_ No one else who does this work uses them

6.\_\_\_\_ Too uncomfortable or difficult to use

7.\_\_\_\_ Not readily available in work area

8.\_\_\_\_ Other (specify)

1. During the past 7 calendar days, did you wear any of the following during electrosurgery? **(Select all that apply)**

|  |  |  |
| --- | --- | --- |
| 1.\_\_\_\_ N95 respirator (including surgical N95 respirator)  N95_3M1860_150x150.jpg | 2.\_\_\_\_ Half-facepiece air purifying respirator with particulate filter(s)  Half-facepieceAPR_3M_150x150.jpg | 3.\_\_\_\_ Powered air purifying respirator (PAPR) with particulate filter(s)  PAPR_3M_150x150.jpg |
| 4.\_\_\_\_ Standard surgical mask | 5.\_\_\_\_ Laser mask  laser mask.jpg | 6.\_\_\_\_ Other (specify)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 7.\_\_\_\_ I did not wear any respirators or masks | 8.\_\_\_\_ I don’t know |  |

**IF N95 RESPIRATOR, HALF-FACEPIECE, OR PAPR SELECTED:**

* 1. How often did you wear a N95 respirator, half-facepiece

air purifying respirator with particulate filter(s), or powered

air purifying respirator with particulate filter(s) during

electrosurgery? 1.\_\_\_\_ Always

2.\_\_\_\_ Sometimes

**IF N95 RESPIRATOR OR HALF-FACEPIECE SELECTED:**

* 1. Have you been fit-tested for the respirator(s) you use

during electrosurgery? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF QUESTION #42 is “I did not wear any respirators or masks” OR QUESTION #42.1 is SOMETIMES:**

* 1. What were the reason(s) you did not always wear a N95

respirator, a half-facepiece air purifying respirator with

particulate filter(s), or a powered air purifying respirator

with particulate filter(s) during electrosurgery?

**(Select all that apply)** 1.\_\_\_\_ An engineering control (e.g., local exhaust ventilation) was being used

2.\_\_\_\_ Exposure was minimal

3.\_\_\_\_ Not part of our protocol

4.\_\_\_\_ Not provided by employer

5.\_\_\_\_ No one else who does this work uses them

6.\_\_\_\_ Too uncomfortable or difficult to use

7.\_\_\_\_ Not readily available in work area

8.\_\_\_\_ Other (specify)

**IF MORE THAN ONE REASON CHECKED:**

* + 1. Of the reasons you selected, please indicate the

most important reason you did not always wear

a respirator during electrosurgery. **(Select one)** 1.\_\_\_\_ An engineering control (e.g., local exhaust ventilation) was being used

2.\_\_\_\_ Exposure was minimal

3.\_\_\_\_ Not part of our protocol

4.\_\_\_\_ Not provided by employer

5.\_\_\_\_ No one else who does this work uses them

6.\_\_\_\_ Too uncomfortable or difficult to use

7.\_\_\_\_ Not readily available in work area

8.\_\_\_\_ Other (specify)

**FOR EACH ITEM SELECTED in QUESTION #37.1 (items cleaned, disinfected, or sterilized):**

1. What PPE do you typically wear when performing cleaning, disinfecting, or sterilizing of:

|  |  |
| --- | --- |
| **Only show/complete for items cleaned, disinfected, or sterilized from QUESTION #37.1.** | **Select all that apply:** |
| * 1. Animal cages, kennels, or runs | 1.\_\_\_\_ Gloves  2.\_\_\_\_ Goggles  3.\_\_\_\_ Surgical mask  4.\_\_\_\_ Face shield  5.\_\_\_\_ Gown or apron  6.\_\_\_\_ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * 1. Litter boxes | 1.\_\_\_\_ Gloves  2.\_\_\_\_ Goggles  3.\_\_\_\_ Surgical mask  4.\_\_\_\_ Face shield  5.\_\_\_\_ Gown or apron  6.\_\_\_\_ Other (specify) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * 1. Bird cages | 1.\_\_\_\_ Gloves  2.\_\_\_\_ Goggles  3.\_\_\_\_ Surgical mask  4.\_\_\_\_ Face shield  5.\_\_\_\_ Gown or apron  6.\_\_\_\_ Other (specify) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * 1. Barn stalls | 1.\_\_\_\_ Gloves  2.\_\_\_\_ Goggles  3.\_\_\_\_ Surgical mask  4.\_\_\_\_ Face shield  5.\_\_\_\_ Gown or apron  6.\_\_\_\_ Other (specify) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * 1. Other area(s) containing animal wastes (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1.\_\_\_\_ Gloves  2.\_\_\_\_ Goggles  3.\_\_\_\_ Surgical mask  4.\_\_\_\_ Face shield  5.\_\_\_\_ Gown or apron  6.\_\_\_\_ Other (specify) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * 1. Medical equipment/instruments | 1.\_\_\_\_ Gloves  2.\_\_\_\_ Goggles  3.\_\_\_\_ Surgical mask  4.\_\_\_\_ Face shield  5.\_\_\_\_ Gown or apron  6.\_\_\_\_ Other (specify) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * 1. Surfaces, such as examination tables, surgery tables, and counters | 1.\_\_\_\_ Gloves  2.\_\_\_\_ Goggles  3.\_\_\_\_ Surgical mask  4.\_\_\_\_ Face shield  5.\_\_\_\_ Gown or apron  6.\_\_\_\_ Other (specify) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section VI. Work Information**

**The next set of questions are about your workplace and work history.**

1. Where do you currently work (facility name)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(online questionnaire to allow choice of participating facilities)

1. When did you start working at this facility? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

1. What is your current position in clinical

veterinary practice? **(Select one.)** 1.\_\_\_\_ Veterinarian (Owner/Partner)

2.\_\_\_\_ Veterinarian (Associate)

3.\_\_\_\_ Veterinarian (Relief)

4.\_\_\_\_ Veterinary technologist

5.\_\_\_\_ Veterinary technician

6.\_\_\_\_ Veterinary assistant

7.\_\_\_\_ Student (veterinary school)

8.\_\_\_\_ Student (veterinary technology school)

9.\_\_\_\_ Student (veterinary technician school)

10.\_\_\_\_ Office staff

11.\_\_\_\_ Kennel help

12.\_\_\_\_ Volunteer

13.\_\_\_\_ Other (specify)

**IF Veterinarian (Owner/Partner), (Associate), (Relief):**

* 1. What year did you graduate veterinary school? \_\_ \_\_ \_\_ \_\_

(Year)

**IF Veterinary technologist:**

* 1. What year did you graduate veterinary technologist school? \_\_ \_\_ \_\_ \_\_

(Year)

* 1. Are you credentialed by your

state (i.e., possess an RVT, LVT, or CVT)? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF Veterinary technician:**

* 1. What year did you graduate veterinary technician school? \_\_ \_\_ \_\_ \_\_

(Year)

* 1. Are you credentialed by your

state (i.e., possess an RVT, LVT, or CVT)? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

1. When did you first start working (or volunteering) in *any*

veterinary clinic setting? \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

(Month) (Year)

1. Have you ever worked in a veterinary clinic setting outside of

the United States? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. In what country(ies) did you work in a veterinary

clinic setting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. When did you work there? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. On average, how many **hours per day** do you currently work? \_\_\_\_\_\_\_\_ hours
2. On average, how many **days per week** do you currently work? \_\_\_\_\_\_\_\_ days
3. At your veterinary clinic, what types of animals are treated…

|  |  |
| --- | --- |
| * 1. …by **any** veterinary personnel?   **(Select all that apply.)**  *(If you work at multiple clinics, choose the practice type for the clinic where you work the most number of* ***hours per week****.)* | * 1. …by **you**?   **(Select all that apply.)**  *(If you work at multiple clinics, choose the practice type for the clinic where you work the most number of* ***hours per week****.)* |
| 1.\_\_\_\_ Cats | 1.\_\_\_\_ Cats |
| 2.\_\_\_\_ Dogs | 2.\_\_\_\_ Dogs |
| 3.\_\_\_\_ Rabbits | 3.\_\_\_\_ Rabbits |
| 4.\_\_\_\_ Ferrets | 4.\_\_\_\_ Ferrets |
| 5.\_\_\_\_ Small rodents (e.g., rats, mice, hamsters) | 5.\_\_\_\_ Small rodents (e.g., rats, mice, hamsters) |
| 6.\_\_\_\_ Other pocket pets (e.g., sugar gliders, hedgehogs, chinchillas) | 6.\_\_\_\_ Other pocket pets (e.g., sugar gliders, hedgehogs, chinchillas) |
| 7.\_\_\_\_ Horses | 7.\_\_\_\_ Horses |
| 8.\_\_\_\_ Cattle (dairy or beef) | 8.\_\_\_\_ Cattle (dairy or beef) |
| 9.\_\_\_\_ Sheep | 9.\_\_\_\_ Sheep |
| 10.\_\_\_\_ Goats | 10.\_\_\_\_ Goats |
| 11.\_\_\_\_ Pigs | 11.\_\_\_\_ Pigs |
| 12.\_\_\_\_ Camelids (llamas, alpacas) | 12.\_\_\_\_ Camelids (llamas, alpacas) |
| 13.\_\_\_\_ Birds (non-poultry) | 13.\_\_\_\_ Birds (non-poultry) |
| 14.\_\_\_\_ Poultry | 14.\_\_\_\_ Poultry |
| 15.\_\_\_\_ Reptiles or amphibians | 15.\_\_\_\_ Reptiles or amphibians |
| 16.\_\_\_\_ Wildlife | 16.\_\_\_\_ Wildlife |
| 17.\_\_\_\_ Non-human primates | 17.\_\_\_\_ Non-human primates |
| 18.\_\_\_\_ Zoo animals | 18.\_\_\_\_ Zoo animals |
| 19.\_\_\_\_ Other (specify) | 19.\_\_\_\_ Other (specify) |

1. Does your veterinary clinic have a fragrance-free

policy? 1.\_\_\_ Yes 0. \_\_\_ No 2. \_\_\_ Don’t Know

1. Do you regularly interact with animals outside of your

veterinary clinic (e.g., pets at home, other non-veterinary

jobs, recreational horse riding, etc.)? 1.\_\_\_\_ Yes 0. \_\_\_\_ No

**IF YES:**

* 1. What species do you regularly interact with outside

of your veterinary clinic? **(Select all that apply.)** 1.\_\_\_\_ Cats

2.\_\_\_\_ Dogs

3.\_\_\_\_ Rabbits

4.\_\_\_\_ Ferrets

5.\_\_\_\_ Small rodents (e.g., rats, mice, hamsters)

6.\_\_\_\_ Other pocket pets (e.g., sugar gliders, hedgehogs, chinchillas)

7.\_\_\_\_ Horses

8.\_\_\_\_ Cattle (dairy or beef)

9.\_\_\_\_ Sheep

10.\_\_\_\_ Goats

11.\_\_\_\_ Pigs

12.\_\_\_\_ Camelids (llamas, alpacas)

13.\_\_\_\_ Birds (non-poultry)

14.\_\_\_\_ Poultry

15.\_\_\_\_ Reptiles or amphibians

16.\_\_\_\_ Wildlife

17.\_\_\_\_ Non-human primates

18.\_\_\_\_ Zoo animals

19.\_\_\_\_ Other (specify)

**Section VII: Workplace Safety Climate**

**Please indicate how much you agree or disagree with each of the following statements about safety practices at your workplace.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Strongly Disagree  (1) | Somewhat Disagree  (2) | Somewhat Agree  (3) | Strongly Agree  (4) | Does Not Apply  (-99) |
| A. Management reacts quickly to solve the problem when told about safety hazards |  |  |  |  |  |
| B. Management insists on thorough and regular safety audits and inspections |  |  |  |  |  |
| C. Management provides all the equipment needed to do the job safely. |  |  |  |  |  |
| D. Management invests a lot of time and money in safety training for workers. |  |  |  |  |  |
| E. Management listens carefully to workers’ ideas about improving safety. |  |  |  |  |  |
| F. Management gives safety personnel the power they need to do their job. |  |  |  |  |  |

**Section VIII: Stress**

**The next two questions are about stress. Stress means a situation in which a person feels tense, restless, nervous or anxious, or is unable to sleep because his/her mind is troubled all the time.**

1. During the past 4 weeks, including today, how would you rate

your stress **outside of work** on a scale from 0 (as low as it can

be) to 10 (as high as it can be)? \_\_\_\_\_\_\_\_ rating

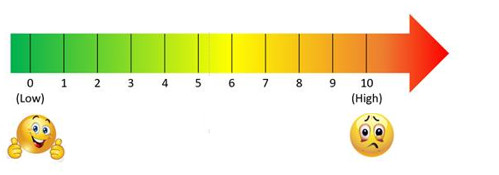
(online questionnaire to display stress thermometer image)

1. During the past 4 weeks, including today, how would you rate

your stress **at work** on a scale from 0 (as low as it can be) to

10 (as high as it can be)? \_\_\_\_\_\_\_\_ rating

(online questionnaire to display stress thermometer image)



**Section IX: Tobacco Use Information**

**The next questions are about tobacco use**.

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

* 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:**

* + 1. How old were you when you stopped

smoking cigarettes regularly? \_\_\_\_\_\_\_\_ years

**IF prior to any site visit to facility:**

Thank you for your participation in the baseline questionnaire of this study on surgical smoke in veterinary clinical settings.

We will be at [facility name] on [dates], and for every day that you are working during that time, you will be invited to participate in the brief, post-shift questionnaire that will ask about respiratory and eye symptoms you had during your shift. Each post-shift questionnaire should take approximately 8 minutes or less. We thank you for your participation today, and look forward to seeing you when we are at [facility name] soon!

**IF after final site visit to facility:**

Thank you for your participation in this study on surgical smoke in veterinary clinical settings.