

Post-shift Questionnaire

Unique ID: _____ Date (MM/DD/YYYY): _____ Time (24 hr): _____
 Facility Name: _____

Symptom	Did you have this symptom during your shift?	Did you have this symptom when you arrived at work today?	Did this symptom worsen during your shift?	Approximately how many hours into your shift did this symptom first start (or worsen if you had this symptom when you arrived at work today)?	What task(s) were you doing when the symptom first started (or worsened if you had this symptom when you arrived at work today)?
Breathing trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Shortness of breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Cough	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Wheezing or whistling in the chest	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Chest tightness	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Stuffy, itchy, or runny nose	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Stinging or burning nose	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Sneezing	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Throat irritation (dry, sore, burning throat) or hoarseness	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Watery or itchy eyes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Stinging or burning eyes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Headache	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Any other respiratory symptoms? (specify) _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	
Any other symptoms? (specify) _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> less than 1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4+	

Did you use cleaning, disinfecting, or sterilizing products today? No Yes Specify: _____

At any time today, did you work within 5 feet of the source of surgical smoke? No Yes

What animal(s) were you around today? (Select all that apply) Dogs Cats Rabbits Ferrets Small rodents Other pocket pets Horses Cattle Sheep Goats Pigs Camelids (llamas, alpacas) Birds/Poultry Reptiles Amphibians Wildlife

Public reporting burden of this collection of information is estimated to average 8 minutes 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 Reports Clearance Officer; 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30333 ATTN: PRA (0920-XXXX).