

PAST 24 HOURS QUESTIONNAIRE - V3

Please give your completed form to the EMSI examiner.

PLEASE COMPLETE ON DAY OF EXAMINER VISIT.

Instructions:

- Use the enclosed pen or any DARK BLUE OR BLACK BALLPOINT PEN.
- Mark only one answer for each question unless otherwise indicated.
- Do not write comments on the form.
- Please keep this questionnaire clean, flat, and dry.
- Do not fold or tear any of the pages.

Fill in the bubbles COMPLETELY for each of the questions in this form.

Like this:

Not like this:





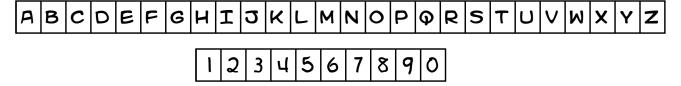
If you must change an answer, please mark a single horizontal line through it and bubble in the correct answer completely.



Not like this:



Please write responses in all capital letters and numbers without touching the sides of the boxes.



When writing dates, please follow this example.

EXAMPLE: June 7, 2004 =

Public reporting burden for this collection of information is estimated to average 10 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: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0522). Do not return the completed form to this address.

1. Date of examiner visit:

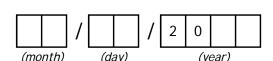
	/			/	2	0		
шш								
(month)		(d	ay)			(ye	ear)	

Questions 2-7 are about your urine sample. If you were not able to give a sample, fill in the bubble for "No" and choose the main reason why not.

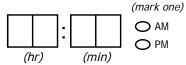
2. Did you collect a urine sample?

 \bigcirc Yes \rightarrow

3. What date did you collect your urine sample? (Date must be the same as on URINE 1 and URINE 2 labels.)



4. What time did you collect your urine? (Time must be the same as on URINE 1 and URINE 2 labels.)



5. Was this a "first morning" urine, that is, the first urine after you woke up for your day?



O Yes

6. What time did you last urinate PRIOR to this collection?

				O AM
	•			O PM
(hr)		(min))	

 \bigcirc No \rightarrow

- 7. If you did not collect a urine sample, please give the <u>main</u> reason why not. (Please mark one.)
- Refused
- O No urine cup
- O None of the above, some other reason

○ Yes →	9. What time was the shift?	
○ No	START TIME: (mark one) AM (hr) (min)	END TIME: (mark one) AM (hr) (min)

10. What time did you go to bed with the intention of sleeping? Do not include the time you spent reading, watching television, etc. (If you didn't go to sleep, mark "Didn't go to sleep.")



8. Did you work a night shift during the past 24 hours?

11. How long did it take you to fall asleep? Would you say you fell asleep within... (Please mark one. If you didn't go to sleep, mark "Didn't go to sleep.")

OR

- O less than 15 minutes
- 15 minutes to half an hour
- O more than half an hour but less than one hour
- O one hour or more
- 12. Please mark "Yes" or "No" for each of the following types of light that may have been present while you were sleeping. (If you didn't go to sleep, mark "Didn't go to sleep" and leave questions a-g blank.)

O Didn't go to sleep

Yes No What kind of light was present while you were sleeping?

0	0	a. daylight
0	0	b. one or more lights on in the room
0	0	c. light from a television on in the room for most or all of the night
0	0	d. light from other rooms
0	0	 e. light from outside shining in through windows at night, such as car headlights, streetlights, or porch lights
0	0	f. light from a small nightlight or clock radio
0	0	g. no light at all

OR

O Didn't go to sleep

13. Did you sleep	with a mask on to keep or	ut light?	
○ Yes○ No	0	R 🔘 Didn't go t	o sleep
14. What time did	d you wake up for the day? (mark one) AM PM PM		o sleep
from the tota	many hours did you sleep? al only if you were awake a AND OF MINUTES	at least 30 minutes.	
toenails, fill in th even if one toena		pose the main reason	were not able to collect your on why not. Please mark "Yes"
○ No →	17. If you did not collec please give the <u>mair</u> (Please mark one.)	-	 Not allowed to cut own nails for medical reasons Can't cut my own nails for other reasons Toenails are too short Nail polish/pedicure I forgot None of the above, some other reason

Questions 18-20 are about your dust samples. If you were not able to collect dust, fill in the bubble for "No" and choose the main reason why not.

18. Did	uov t	collect	and	aive	dust	samples	to	the	examiner?
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○ Yes →			mark "YES" or "NO" for each. You should collect dust from no han 3 different surfaces.
	Yes	No	From what surfaces did you collect dust samples?
	0	0	a. Painted wood
	0	0	b. Unfinished wood
	0	0	 c. Wood finished in some other way such as a stain, varnish, or polyurethane
	0	0	d. Painted metal
	0	0	e. Unpainted metal
	0	0	f. Painted stucco
	0	0	g. Painted drywall
	0	0	h. Plastic, Formica, laminate, or vinyl
	0	0	i. Glass, stone, ceramic, or marble

○No →	20.	If you did not collect dust, please	O I forgot
		give the main reason why not.	No alcohol swabs
		(Please mark one.)	None of the above, some other reason

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you dia	not	take	any .	med	dica	tioi	ns ir	the	e las	st 24	4 ho	urs,	fill	in '	00' <i>é</i>	and ;	go t	o qu	iest	ion 2	22.)
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14.																					

22. Have you had past 24 hours	any alcoholic drinks (including wine, wine coolers?	s, beer, and liquor) during the
○ Yes →	23. How many alcoholic drinks have you had in the past 24 hours? (A drink is equal to a 5-ounce glass of wine, one wine cooler, a 12-ounce bottle of beer, or one shot of liquor or one mixed drink.)	NUMBER OF DRINKS:
24. Have you smo	oked any cigarettes during the past 24 hours?	
○ YES →	25. How many cigarettes have you smoked in the past 24 hours?	NUMBER OF CIGARETTES:

26. Please mark "YES" or "NO" for each of the following activities that you may have done <u>in the past 24 hours</u>.

Yes	No	In the past 24 hours, have you
0	0	a. used any form of pesticides or bug repellent?
0	0	b. used solvents such as nail polish remover or paint thinner?
0	0	c. used hair spray, hair gel, or hair mousse?
0	0	d. used overnight cream, lotions, or self-tanners?
0	0	e. applied nail polish to your own or someone else's nails?
0	0	f. used perfume or cologne?
0	0	g. used makeup including foundation, blush, eye makeup, lipstick, etc.?
0	0	h. pumped your own gas?

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past we	<u>ek</u> .	
Yes	No	In the past week, have you
0	0	a. had any medical procedures that required an IV (intravenous line), not including blood or platelet donation?
0	0	b. donated blood, not including platelet donation?
0	0	c. donated platelets, not including blood donation?
0	0	d. had major dental work, such as root canal, implants, gum surgery, etc.?
_		e had routine dental work such as cleanings fillings including crowns and

•27. Please mark "YES" or "NO" for each of the following activities that you may have done in the

28. Please mark "YES" or "NO" for each of the following activities that may have taken place inside your home in the past 4 weeks.

f. had surgery on any area other than mouth?

Yes No In the past 4 weeks, have you...

x-rays?

0

162	INO	iii tile past 4 weeks, liave you			
0	0	a. added new furniture?			
0	0	b. added new carpeting?			
0	0	c. added new linoleum or vinyl flooring?			
0	0	d. added new pet(s)? (Only include pets with fur or feathers.)			
0	0	e. lost or given up family pet(s)? (Only include pets with fur or feathers.)			
0	0	f. done major "spring cleaning"?			
0	0	g. refinished wood floors?			
0	0	 h. done other renovation, remodeling, or construction work (such as kitchen or bathroom remodeling, knocking down or adding walls)? 			
0	0	i. added new paint or wallpaper?			
0	0	j. installed new heating, cooling or ventilation system?			
0	0	k. installed new air filtration system?			
0	0	I. had pesticide treatment?			
0	0	m. had flood damage or other water damage?			
0	0	n. done any other activity that may affect the amount or type of dust in your home?			

Did this activity make your home more dusty or less dusty?

o more dusty

O less dusty

PLEASE ANSWER QUESTIONS 29 AND 30 ONLY IF YOU HAD A MENSTRUAL PERIOD IN THE PAST 12 MONTHS.



- 29. Do you take any type of birth control pill, hormonal birth control, or hormone replacement therapy?
- O Yes
- O No
- 30. What was the first day of your last menstrual period?

		/	2	0		
(month)	(day)	(vear)				

Please check to see that all questions are answered. Give this questionnaire to the EMSI examiner when she comes for your home visit.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

FOR OFFICE USE ONLY: If this form was not completed by respondent, check here									
Initials:	Date:/ [(day) / [2	2 0 (year)						