Form: 04 Vers: 03 ID#:

OMB No. 0925-0522

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.

Like this: ● ~~YES~~ Not like this: ● ~~X~~ES

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

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z

1	2	3	4	5	6	7	8	9	0

When writing dates, please follow this example.

EXAMPLE: June 7, 2004 = 0 6 / 0 7 / 2 0 0 4

(month) (day) (year)

1. Date of examiner visit: ☐☐ / ☐☐ / 2 0 ☐☐
(month) *(day)* *(year)*

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?

○ Yes →

3. What date did you collect your urine sample? *(Date must be the same as on URINE 1 and URINE 2 labels.)*
☐☐ / ☐☐ / 2 0 ☐☐
(month) *(day)* *(year)*

4. What time did you collect your urine? *(Time must be the same as on URINE 1 and URINE 2 labels.)*
☐☐ : ☐☐ *(mark one)* ○ AM ○ PM
(hr) *(min)*

5. Was this a "first morning" urine, that is, the first urine after you woke up for your day?
○ Yes
○ No

6. What time did you last urinate PRIOR to this collection?
☐☐ : ☐☐ *(mark one)* ○ AM ○ PM
(hr) *(min)*

○ No →

7. If you did not collect a urine sample, please give the main reason why not. *(Please mark one.)*
○ Refused
○ No urine cup
○ None of the above, some other reason

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

○ Yes → 9. What time was the shift?

START TIME: ☐☐ : ☐☐ (hr) (min) (mark one) ○ AM ○ PM

END TIME: ☐☐ : ☐☐ (hr) (min) (mark one) ○ AM ○ PM

○ No

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.")*

☐☐ : ☐☐ (hr) (min) (mark one) ○ AM ○ PM

OR ○ Didn't go to sleep

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.")

○ less than 15 minutes
○ 15 minutes to half an hour
○ more than half an hour but less than one hour
○ one hour or more

OR ○ Didn't go to sleep

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.)*

Yes	No	What kind of light was present while you were sleeping?
○	○	a. daylight
○	○	b. one or more lights on in the room
○	○	c. light from a television on in the room for most or all of the night
○	○	d. light from other rooms
○	○	e. light from outside shining in through windows at night, such as car headlights, streetlights, or porch lights
○	○	f. light from a small nightlight or clock radio
○	○	g. no light at all

OR

○ Didn't go to sleep

Please use a ballpoint pen for this form

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13. Did you sleep with a mask on to keep out light?

○ Yes
○ No

OR ○ Didn't go to sleep

14. What time did you wake up for the day?

☐☐ : ☐☐ *(mark one)* ○ AM ○ PM
(hr) *(min)*

OR ○ Didn't go to sleep

15. In total, how many hours did you sleep? (*If you woke up during your sleep, subtract the time from the total only if you were awake at least 30 minutes.)*

☐☐ # OF HOURS **AND** ☐☐ # OF MINUTES

OR ○ Didn't go to sleep

Questions 16 and 17 are about your toenail clippings. If you were not able to collect your toenails, fill in the bubble for "No" and choose the main reason why not. Please mark "Yes" even if one toenail clipping was collected.

16. Did you collect and give toenail clippings to the examiner?

○ Yes
○ No →

17. If you did not collect your toenails, please give the main reason why not. *(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 you collect and give dust samples to the examiner?

○ Yes →

19. *Please mark "YES" or "NO" for each. You should collect dust from no more than 3 different surfaces.*

Yes	No	From what surfaces did you collect dust samples?
○	○	a. Painted wood
○	○	b. Unfinished wood
○	○	c. Wood finished in some other way such as a stain, varnish, or polyurethane
○	○	d. Painted metal
○	○	e. Unpainted metal
○	○	f. Painted stucco
○	○	g. Painted drywall
○	○	h. Plastic, Formica, laminate, or vinyl
○	○	i. Glass, stone, ceramic, or marble

○ No →

20. If you did not collect dust, please give the main reason why not. *(Please mark one.)*

- ○ I forgot
- ○ No alcohol swabs
- ○ None of the above, some other reason

Please use a ballpoint pen for this form

21. How many different medications did you take <u>in the last 24 hours</u>? *(Please include all prescribed medications, including pills, patches, liquids, injections, inhalers, creams, etc. AND all non-prescribed or over-the-counter medications AND all vitamins and supplements.)*

(If you did not take any medications in the last 24 hours, fill in '00' and go to question 22.)

TOTAL NUMBER OF MEDICATIONS, VITAMINS, AND SUPPLEMENTS: ☐☐

21a. Copy the names off your medication bottles or packages directly to make sure that the spelling is correct. **Please do not include dosage or frequency of use.**

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

13.

14.

IF YOU TOOK MORE THAN 14 MEDICATIONS, PLEASE WRITE DOWN EACH MEDICATION ON A SEPARATE PIECE OF PAPER.

22. Have you had any alcoholic drinks (including wine, wine coolers, beer, and liquor) during the past 24 hours?

○ 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: ☐☐

○ No

24. Have you smoked any cigarettes during the past 24 hours?

○ YES →

25. How many cigarettes have you smoked in the past 24 hours?

NUMBER OF CIGARETTES: ☐☐

○ NO

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...
○	○	a. used any form of pesticides or bug repellent?
○	○	b. used solvents such as nail polish remover or paint thinner?
○	○	c. used hair spray, hair gel, or hair mousse?
○	○	d. used overnight cream, lotions, or self-tanners?
○	○	e. applied nail polish to your own or someone else's nails?
○	○	f. used perfume or cologne?
○	○	g. used makeup including foundation, blush, eye makeup, lipstick, etc.?
○	○	h. pumped your own gas?

Please use a ballpoint pen for this form

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

Yes	No	In the past week, have you...
○	○	a. had any medical procedures that required an IV (intravenous line), not including blood or platelet donation?
○	○	b. donated blood, not including platelet donation?
○	○	c. donated platelets, not including blood donation?
○	○	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 x-rays?
○	○	f. had surgery on any area other than mouth?

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.

Yes	No	In the past 4 weeks, have you...
○	○	a. added new furniture?
○	○	b. added new carpeting?
○	○	c. added new linoleum or vinyl flooring?
○	○	d. added new pet(s)? (Only include pets with fur or feathers.)
○	○	e. lost or given up family pet(s)? (Only include pets with fur or feathers.)
○	○	f. done major "spring cleaning"?
○	○	g. refinished wood floors?
○	○	h. done other renovation, remodeling, or construction work (such as kitchen or bathroom remodeling, knocking down or adding walls)?
○	○	i. added new paint or wallpaper?
○	○	j. installed new heating, cooling or ventilation system?
○	○	k. installed new air filtration system?
○	○	l. had pesticide treatment?
○	○	m. had flood damage or other water damage?
○	○	n. done any other activity that may affect the amount or type of dust in your home?

ANSWER ONLY IF YOU MARKED YES TO ITEM "n" ABOVE:

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

○ more dusty
○ 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?

- ⬭ Yes
- ⬭ No

30. What was the first day of your last menstrual period?

		/			/	2	0		
(month)			*(day)*			*(year)*			

Please use a ballpoint pen for this form

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: ☐☐ / ☐☐ / 20☐☐
(month) *(day)* *(year)*