

12/14/91

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Medical Monitoring Program
Adult Participant Health Questionnaire

Instructions

1. The questions in this questionnaire are related to health habits, health beliefs, exposure to chemicals, occupation, and hobbies. The information will be used to determine your health status. We hope you will assist us with the program. Thank you.
2. Please answer as completely and accurately as possible. If you do not understand a question, please circle it and discuss it with the nurse.
3. If you are uncertain of the answer to a question, give your best guess. DO NOT leave an answer blank, a blank will indicate it was accidently skipped.

Date of Birth _____ / _____ / 19____
 month day year

1. Have you ever smoked at least one cigarette per day for a year or longer OR have you smoked at least 20 packs in your whole life?

_____ 1. Yes _____ 2. No If NO, skip to question 2.

If YES, answer the following questions:

1a. Do you smoke cigarettes now?

_____ 1. Yes _____ 2. No

1b. If NO to 1a, how old were you when you stopped completely?

_____ Age

1c. How old were you when you started smoking cigarettes?

_____ Age

1d. How many total years have you smoked at least one cigarette per day? (If you did not smoke for awhile, do not include those years you did not smoke.)

_____ Years

1e. On the average for the entire time you smoked, how many cigarettes did you smoke per day?

_____ Cigarettes per day

2. Have you ever smoked cigars or a pipe on a regular basis? ("Yes" means more than 1 cigar a week for a year, or more than 12 oz of pipe tobacco in your whole life).

_____ 1. Yes _____ 2. No If NO, skip to question 3.

If YES, answer the following questions:

2a. Do you or did you inhale the pipe or cigar smoke?

_____ 1. Yes _____ 2. No

2b. Do you currently smoke cigars or a pipe?

_____ 1. Yes _____ 2. No

2c. How many cigars do you usually smoke per day?

_____ cigars per day

2d. How many pipes of tobacco do you usually smoke per day?

_____ pipes of tobacco

2e. How many times per day do you usually use smokeless tobacco (chew, snuff)? Put 0 if none.

_____ times per day

3. How often do you use drugs or medication (including prescription drugs) which affect your mood or help you to relax? (check one)

- _____ (1) Almost every day
_____ (2) Sometimes
_____ (3) Rarely or never

4. How many drinks of alcoholic beverages do you have in a typical week? (write the number of each type of drink)

- _____ Bottles or cans of beers (12 oz.)
_____ Wine coolers (12 oz.)
_____ Glasses of wine (6 oz.)
_____ Mixed drinks or shots of liquor (1.5 oz.)

5. How many time in the last month did you drive or ride when the driver had perhaps too much alcohol to drink?
- _____ Times last month
6. In the next 12 months, how many thousands of miles will you probably travel (as a driver or passenger) by each of the following?
- a. Car, truck or van _____,000 miles (10,000 is average)
b. Motorcycle _____,000 miles
7. What percent of the time do you usually buckle your safety belt when driving or riding?
- _____ %
8. On the average, how close to the speed limit do you usually drive?
- _____ (1) Within 5 mph of the speed limit
_____ (2) 6-10 mph over the limit
_____ (3) 11-15 mph over the limit
_____ (4) More than 15 mph over the limit
9. When riding a motorcycle or all-terrain vehicle, what percent of the time do you wear a helmet?
- _____ (1) More than 75% of the time
_____ (2) 25-74% of the time
_____ (3) Less than 25% of the time
_____ (4) Does not apply to me
10. How often do you eat food that is high in fiber such as whole grain bread, cereal, fresh fruits or vegetables?
- _____ (1) Daily
_____ (2) 5-6 days a week
_____ (3) 3-4 days a week
_____ (4) 1-2 days a week
_____ (5) Rarely never
11. How often do you eat food that is high in cholesterol or fat, such as fatty meats, cheese, fried foods or eggs?
- _____ (1) Daily
_____ (2) 5-6 days a week
_____ (3) 3-4 days a week
_____ (4) 1-2 days a week
_____ (5) Rarely never

12. On the average, how many times per week do you engage in physical activity, exercise or work which increases the heart rate, causes you to breathe and sweat heavily, and is done for at least 20 minutes in duration? Examples include running, swimming, racquet sports, cycling, brisk walking or heavy labor, e.g. chopping, lifting, digging, etc.

- _____ (1) Less than 1 time per week
- _____ (2) 1 or 2 times per week
- _____ (3) At least 3 times per week

13. How many hours of sleep do you usually get a night? (check one)

- _____ (1) 6 hours or less
- _____ (2) 7 hours
- _____ (3) 8 hours
- _____ (4) 9 hours or more

14. Would you participate in a program that would help you to enhance your overall health?

- _____ (1) Yes
- _____ (2) No
- _____ (3) Not sure

15. Have you made any of the following changes to enhance your health during the last 12 months? (check one on each line)

I have exercised more

- _____ (1) Yes _____ (2) No _____ (3) I didn't need to change

I have lost weight

- _____ (1) Yes _____ (2) No _____ (3) I didn't need to change

I have reduced alcohol use

- _____ (1) Yes _____ (2) No _____ (3) I didn't need to change

I have quit or cut down on smoking

- _____ (1) Yes _____ (2) No _____ (3) I didn't need to change

I have reduced fat and cholesterol intake

- _____ (1) Yes _____ (2) No _____ (3) I didn't need to change

I have coped better with stress

- _____ (1) Yes _____ (2) No _____ (3) I didn't need to change

I have lowered my blood pressure

___ (1) Yes ___ (2) No ___ (3) I didn't need to change

Other (specify _____)

___ (1) Yes ___ (2) No

16. On a typical day how do you usually travel? (check one only)

- ___ (1) Walk
- ___ (2) Bicycle
- ___ (3) Motorcycle
- ___ (4) Sub-compact or compact car
- ___ (5) Mid-size or full-size car
- ___ (6) Truck or van
- ___ (7) Bus, subway or train
- ___ (8) Mostly stay at home

17. In general, how satisfied are you with your life (include personal and professional aspects)? (check one)

- ___ (1) Completely satisfied
- ___ (2) Mostly satisfied
- ___ (3) Partly satisfied
- ___ (4) Not satisfied

18. Would you agree you are satisfied with your job? (check one)

- ___ (1) Agree strongly
- ___ (2) Agree
- ___ (3) Disagree
- ___ (4) Disagree strongly
- ___ (5) Not currently employed

19. In general, how strong are your social ties with your family and friends? (check one)

- ___ (1) Very strong
- ___ (2) About average
- ___ (3) Weaker than average
- ___ (4) Not sure

20. Considering your age, how would you describe your overall physical health? (check one)

- ___ (1) Excellent
- ___ (2) Good
- ___ (3) Fair
- ___ (4) Poor

21. Have you suffered a personal loss or misfortune in the past year that had a serious impact on your life? (For example, a job loss, disability, divorce, separation, jail term, or the death of someone close to you.)

- _____ (1) Yes, two or more serious losses
_____ (2) Yes, one serious loss or misfortune
_____ (3) No

22. How many times in the past year did you witness or become involved in a violent fight or attack where there was a good chance of serious injury to someone? (check one)

- _____ (1) 4 or more times
_____ (2) 2 or 3 times
_____ (3) Once or never
_____ (4) Not sure

23. Would you agree you have your life in perspective?

- _____ (1) Strongly agree
_____ (2) Agree
_____ (3) Netural
_____ (4) Disagree
_____ (5) Strongly disagree

24. Concerning your daily life, would you agree that you have control over the day to day decisions affecting your function or performance? (check one)

- _____ (1) Strongly agree
_____ (2) Agree
_____ (3) Neutral
_____ (4) Disagree
_____ (5) Strongly disagree

25. In the past year, how many days of work or school have you missed due to personal illness? (check one)

- _____ (1) 0-days
_____ (2) 1-2 days
_____ (3) 3-5 days
_____ (4) 6-10 days
_____ (5) 11-15 days
_____ (6) 16 days or more
_____ (7) Not currently employed or going to school.

26. Are you aware of potential safety and environmental hazards around you? (check one)

- _____ (1) All of the time
- _____ (2) Most of the time
- _____ (3) Some of the time
- _____ (4) Rarely
- _____ (5) None of the time

27. Do you have a family history (brother, sister, mother, father, grandparents) of:

27a. High Blood Pressure

_____ (1) Yes _____ (2) No _____ (3) I'm not sure

27b. Heart Problems

_____ (1) Yes _____ (2) No _____ (3) I'm not sure

27c. Diabetes

_____ (1) Yes _____ (2) No _____ (3) I'm not sure

27d. Cancer

_____ (1) Yes _____ (2) No _____ (3) I'm not sure

27e. High Cholesterol

_____ (1) Yes _____ (2) No _____ (3) I'm not sure

28. Do you have:

28a. Heart Problems

_____ (1) Yes _____ (2) No _____ (3) I'm not sure

28b. Diabetes

_____ (1) Yes _____ (2) No _____ (3) I'm not sure

28c. Cancer

_____ (1) Yes _____ (2) No _____ (3) I'm not sure

28d. Chronic Bronchitis or Emphysema

_____ (1) Yes _____ (2) No _____ (3) I'm not sure

29. About how long has it been since you had a rectal exam?

- _____ (1) Less than 1 year ago
- _____ (2) 1-2 years ago
- _____ (3) 2-3 years ago
- _____ (4) 3 or more years
- _____ (5) Never

30. Do you suffer from back pain?

- _____ (1) Yes
- _____ (2) No

31. Are you now taking medicine for high blood pressure?

- _____ (1) Yes
- _____ (2) No

WOMEN only answer questions 32a - 32h. (Men go to question 33)

32a. How long has it been since your last breast x-ray (mammogram)?

- _____ (1) Less than 1 year ago
- _____ (2) 1-2 years ago
- _____ (3) 2-3 years ago
- _____ (4) 3 or more years ago
- _____ (5) Never had one

32b. How many women in your natural family (mother and sisters only) have had breast cancer?

_____ Women

32c. Have you had a hysterectomy operation?

- _____ (1) Yes
- _____ (2) No
- _____ (3) I'm not sure

32d. How long has it been since you had a Pap smear test?

- _____ (1) Less than 1 year ago
- _____ (2) 1-2 years ago
- _____ (3) 2-3 years ago
- _____ (4) 3 or more years ago
- _____ (5) Never had one

32e. At what age did you have your first menstrual period?

_____ Years old

32f. How old were you when your first child was born?

_____ Years old (if no children write 0)

32g. How often do you examine your breasts for lumps?

- _____ (1) Monthly
- _____ (2) Once every few months
- _____ (3) Rarely or never

32h. About how long has it been since you had your breasts examined by a physician or nurse?

- _____ (1) Less than 1 year ago
- _____ (2) 1-2 years ago
- _____ (3) 2-3 years ago
- _____ (4) 3 or more years ago
- _____ (5) Never

MEN only answer question 33. (WOMEN go to question 35)

33. About how long has it been since you had a rectal or prostate exam.

- _____ (1) Less than 1 year ago
- _____ (2) 1-2 years ago
- _____ (3) 2-3 years ago
- _____ (4) 3 or more years ago
- _____ (5) Never

34. How often do you examine your testicles for lumps

- _____ (1) Monthly
- _____ (2) Once every few months
- _____ (3) Rarely or never

35. How do you classify your current work?

Non-manufacturing

- 01 advertising, public relations
- 02 agriculture, forestry, fisheries
- 03 banking
- 04 communications
- 05 construction
- 06 computer or information systems
- 07 education
- 08 entertainment, leisure
- 09 finance, credit
- 10 government agencies
- 11 health care professional
- 12 insurance
- 13 investment banking and securities
- 14 military service
- 15 mining
- 16 professional services
- 17 public utilities
- 18 real estate, land development
- 19 retail trade
- 20 transportation, all kinds
- 21 wholesale trade

Manufacturing

- 22 aerospace
- 23 apparel
- 24 automotive
- 25 building products
- 26 chemicals
- 27 computer or office technology
- 28 electrical machinery
- 29 electronics and electrical products
- 30 fabricated metals
- 31 food
- 32 non-electrical machinery
- 33 packaging
- 34 paper
- 35 petroleum
- 36 pharmaceuticals
- 37 plastic and rubber
- 38 primary metals
- 39 printing, publishing
- 40 textiles
- 41 transportation equipment

Other

- 42 student
- 43 retired
- 44 laid off
- 45 homemaker
- 46 volunteer
- 47 unemployed

36. In case we need to get old films:
When was your last chest x-ray 19 ____
What hospital or doctors office was your chest x-ray performed at? _____

37. **Females Only**
When was your last mammogram 19 ____
What hospital was your mammogram performed at?

38. Did someone who lived with you work at the Fernald Plant?

_____ NO Name: _____

_____ YES Relationship: _____

Dates worked at the plant: 19 ____ to 19 ____

INSTRUCTIONS:

This survey asks for your views about your health. This information will be summarized in your medical record and will help your doctors keep track of how you feel and how well you are able to do your usual activities.

Answer every question by circling the appropriate number, 1, 2, 3, ... If you are unsure about how to answer a question, please give the best answer you can and make a comment in the **left margin**.

1. In general, would you say your health is:

(circle one number)

- Excellent 1
- Very Good 2
- Good 3
- Fair 4
- Poor 5

2. Compared to one year ago, how would you rate your health in general now?

(circle one number)

- Much better now than one year ago 1
- Somewhat better now than one year ago 2
- About the same 3
- Somewhat worse now than one year ago 4
- Much worse now than one year ago 5

HEALTH AND DAILY ACTIVITIES

3. The following questions are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much? (Circle 1, 2 or 3 on each line.)

	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at All	
a. <u>Vigorous activities</u> , such as running, lifting heavy objects, participating in strenuous sports	1	2	3	33
b. <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3	34
c. Lifting or carrying groceries	1	2	3	35
d. Climbing <u>several</u> flights of stairs	1	2	3	36
e. Climbing <u>one</u> flight of stairs	1	2	3	37
f. Bending, kneeling, or stooping	1	2	3	38
g. Walking <u>more than a mile</u>	1	2	3	39
h. Walking <u>several blocks</u>	1	2	3	40
i. Walking <u>one block</u>	1	2	3	41
j. Bathing and dressing yourself	1	2	3	42

4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**? (Please answer **YES** or **NO** for each question by circling 1 or 2 on each line.)

	YES	NO
a. Cut down on the <u>amount of time</u> you spent on work or other activities	1	2
b. <u>Accomplished less</u> than you would like	1	2
c. Were limited in the <u>kind</u> of work or other activities	1	2
d. Had <u>difficulty</u> performing the work or other activities (for example, it took extra effort)	1	2

5. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)? (Please answer **YES** or **NO** for each question by circling 1 or 2 on each line.)

	YES	NO
a. Cut down on the <u>amount of time</u> you spent on work or other activities	1	2
b. <u>Accomplished less</u> than you would like	1	2
c. Didn't do work or other activities as <u>carefully</u> as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

(circle one number)

- Not at all 1
Slightly 2
Moderately 3
Quite a bit 4
Extremely 5

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PAIN

7. How much bodily pain have you had during the past 4 weeks?

(circle one number)

- None 1
Very mild 2
Mild 3
Moderate 4
Severe 5
Very severe 6

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8. During the past 4 weeks, how much did pain interfere with your normal work (including work both outside the home and housework)?

(circle one number)

- Not at all 1
A little bit 2
Moderately 3
Quite a bit 4
Extremely 5

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YOUR FEELINGS

9. These questions are about how you feel and how things have been with you during the past month. For each question, please indicate the one answer that comes closest to the way you have been feeling.

How much of the time during the past month ...

(circle one number on each line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time	
a. did you feel full of pep?	1	2	3	4	5	6	53
b. have you been a very nervous person?	1	2	3	4	5	6	54
c. have you felt so down in the dumps nothing could cheer you up?	1	2	3	4	5	6	55
d. have you felt calm and peaceful?	1	2	3	4	5	6	56
e. did you have a lot of energy?	1	2	3	4	5	6	57
f. have you felt downhearted and blue?	1	2	3	4	5	6	58
g. did you feel worn out?	1	2	3	4	5	6	59
h. have you been a happy person?	1	2	3	4	5	6	60
i. did you feel tired?	1	2	3	4	5	6	61
j. has your <u>health limited your social activities</u> (like visiting with friends or close relatives)?	1	2	3	4	5	6	62

10. Please choose the answer that best describes how true or false each of the following statements is for you.

(circle one number on each line)

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
a. I seem to get sick a little easier than other people.	1	2	3	4	5
b. I am as healthy as anybody I know.	1	2	3	4	5
c. I expect my health to get worse.	1	2	3	4	5
d. My health is excellent.	1	2	3	4	5

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2. RESIDENCES/DRINKING WATER

IN ORDER TO DO A COMPLETE EVALUATION OF YOUR HEALTH, IT IS IMPORTANT FOR US TO KNOW WHERE YOU HAVE LIVED AND THE SOURCE OF YOUR DRINKING WATER

1. Please list all the places you have lived in the Fernald area (within miles) since 1952. Include only those places that you lived for 3 months or longer.
2. List the dates that you lived at that residence. Use the number of the month and the last two numbers of the year, September 1947 = 09/47
If you are not sure of the month, but can remember the season, use the following,
 - "summer" - use "07" for the month
 - "fall" - use "10" for the month
 - "winter" - use "01" for the month
 - "spring" - use "04" for the month
 If you have no idea of the month, use "DK" for month.
If you cannot remember the date at all, use "DK/DK".
3. For each residence, indicate the source of your drinking water while you lived there. If you had more than one source, put a "1" in the block for the source you used most frequently, and a "2" in the block for the source you used next most frequently.

STREET ADDRESS City, State and Zip Code	DATES	DRINKING WATER SOURCE
1. How many total years did you live at this residence? _____ yrs.	From -- / -- To -- / --	A. <input type="checkbox"/> Municipal Water Compar B. <input type="checkbox"/> Well Water C. <input type="checkbox"/> Cistern D. <input type="checkbox"/> Bottled Water E. <input type="checkbox"/> Other _____
2. How many total years did you live at this residence? _____ yrs.	From -- / -- To -- / --	A. <input type="checkbox"/> Municipal Water Compar B. <input type="checkbox"/> Well Water C. <input type="checkbox"/> Cistern D. <input type="checkbox"/> Bottled Water E. <input type="checkbox"/> Other _____
3. How many total years did you live at this residence? _____ yrs.	From -- / -- To -- / --	A. <input type="checkbox"/> Municipal Water Compar B. <input type="checkbox"/> Well Water C. <input type="checkbox"/> Cistern D. <input type="checkbox"/> Bottled Water E. <input type="checkbox"/> Other _____

3. OCCUPATIONAL HISTORY

FOR YOUR HEALTH EVALUATION, IT ALSO IS IMPORTANT THAT WE KNOW ABOUT YOUR OCCUPATIONAL HISTORY. CAREFULLY READ THE INSTRUCTIONS BELOW. PLEASE ASK THE NURSE FOR ASSISTANCE IF YOU ARE HAVING DIFFICULTY WITH THIS FORM.

1. Please list any job you have held during your lifetime for 3 months or longer. Include employment on a farm, vocational training, or military experience. Full-time homemakers or retired persons should list that occupation on this form. If you were working two jobs at the same time, please list both jobs on this form.
2. Do not leave any area blank. If you are uncertain of the answer to a question, give it your best guess.
3. List the dates that you worked at this job. Use the number of the month, and the last two numbers of the year.
For example, March, 1951 = 03/51
4. List any substances, dusts, or chemicals that were present in your work area and were in the air or could get on your skin. If you are not sure of the exact name or spelling of the substance, give it your best guess.
5. Indicate protective equipment used.

EXAMPLE

A. Company Name	B. Type of business or primary product	C. Your job title	D. Main activities or duties on this job
Ford Garage	Car repair	Mechanic	work on cars work in stock room

E. Job Began	F. What substances, dust or chemicals did you work with which were in the air or could get on your skin?	G. Did you use any protective equipment? (check all that apply)
Job 1 From 09 / 42 To 05 / 51	Gas, oil	1. <input type="checkbox"/> Mask - paper 2. <input type="checkbox"/> Mask - other 3. <input type="checkbox"/> Gloves 4. <input type="checkbox"/> Other _____

A. Company Name & Address (city, state)	B. Type of business or primary product	C. Your job title	D. Main activities or duties on this job
Job 1 In Fernald 5 mile area? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			
Job 2 In Fernald 5 mile area? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			
Job 3 In Fernald 5 mile area? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			
Job 4 In Fernald 5 mile area? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			
Job 5 In Fernald 5 mile area? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			
Job 6 In Fernald 5 mile area? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			

PLEASE REQUEST ADDITIONAL PAGES IF NECESSARY

E. Job Began Job Ended	F. What substances, dust or chemicals did you work with which were in the air or could get on your skin?	G. Did you use any protective equipment? (check all that apply)
Job 1 From -- / -- To -- / --	How many years did you work at this job? ____ years	1. <input type="checkbox"/> Mask - paper 2. <input type="checkbox"/> Mask - other 3. <input type="checkbox"/> Gloves 4. <input type="checkbox"/> Other _____
Job 2 From -- / -- To -- / --	How many years did you work at this job? ____ years	1. <input type="checkbox"/> Mask - paper 2. <input type="checkbox"/> Mask - other 3. <input type="checkbox"/> Gloves 4. <input type="checkbox"/> Other _____
Job 3 From -- / -- To -- / --	How many years did you work at this job? ____ years	1. <input type="checkbox"/> Mask - paper 2. <input type="checkbox"/> Mask - other 3. <input type="checkbox"/> Gloves 4. <input type="checkbox"/> Other _____
Job 4 From -- / -- To -- / --	How many years did you work at this job? ____ years	1. <input type="checkbox"/> Mask - paper 2. <input type="checkbox"/> Mask - other 3. <input type="checkbox"/> Gloves 4. <input type="checkbox"/> Other _____
Job 5 From -- / -- To -- / --	How many years did you work at this job? ____ years	1. <input type="checkbox"/> Mask - paper 2. <input type="checkbox"/> Mask - other 3. <input type="checkbox"/> Gloves 4. <input type="checkbox"/> Other _____
Job 6 From -- / -- To -- / --	How many years did you work at this job? ____ years	1. <input type="checkbox"/> Mask - paper 2. <input type="checkbox"/> Mask - other 3. <input type="checkbox"/> Gloves 4. <input type="checkbox"/> Other _____

Please check any of the hobbies and leisure time activities listed below to which you devoted 80 or more hours last year.

- a. Gardening ✓
- b. Woodworking .
- c. Stained glass work
- d. Jewelry making
- e. Silk screening
- f. Mimeographing
- g. Paint removal
- h. House painting —
- i. Model plane/car building
- j. Furniture refinishing
- k. Pottery/ceramics —
- l. Indoor firing range practice — 1
- m. Making bullets —
- n. Melting metal for any other purpose
- o. Cut wood with a chain saw
- p. Other _____
- q. Other _____

Please indicate below if you have had known exposures to any of the chemicals, substances, or environments listed below:

- | | |
|--------------------------------------|--|
| _____ a. Methyl mercury | _____ y. Lead |
| _____ b. Vibration | _____ z. Asbestos |
| _____ c. Severe cold | _____ aa. Silica |
| _____ d. Carbon monoxide | _____ bb. High heat |
| _____ e. Organic solvents | _____ cc. Coal |
| _____ f. N-hexane | _____ dd. Talc |
| _____ g. Methyl ethyl ketone (MEK) | _____ ee. Animals or animal fe |
| _____ h. Methyl n-butyl ketone (MBK) | _____ ff. Kerosene/mineral spi |
| _____ i. Kepone | _____ gg. Lubricating oils |
| _____ j. Carbon disulphide | _____ hh. Anesthetic gases |
| _____ k. Acrylamide | _____ ii. Ethylene oxide |
| _____ l. | _____ jj. Dibromochloropropane
(DBCP) |
| _____ m. Manganese | _____ kk. Glycol ethers |
| _____ n. Perchloroethylene | _____ ll. Synthetic hormones |
| _____ o. Trichloroethylene (TCE) | _____ mm. Ionizing radiation |
| _____ p. Thallium | _____ nn. Chemotherapy drugs |
| _____ q. Methyl chloride | _____ oo. Other _____ |
| _____ r. Toluene | _____ pp. Other _____ |
| _____ s. Benzene | |
| _____ t. Organotin compounds | |
| _____ u. Nickel | |
| _____ v. Dimethylaminopropionitrile | |
| _____ w. Methanol | |
| _____ x. Styrene | |

We want to be sure that we haven't missed any jobs that might have been part of your working experience. Listed below are a number of industries. Please check any industries in which you have worked for 6 months or more.

- _____ a. Furniture manufacture
- _____ b. Rubber/tire manufacture
- _____ c. Petroleum refining
- _____ d. Metal machining
- _____ e. Dry cleaning
- _____ f. Gasoline service station
- _____ g. Chemical manufacturing
- _____ h. A battery plant (lead or other storage battery)
- _____ i. Auto mechanic or repair
- _____ j. Plumbing, heating or air conditioning
- _____ k. Printing
- _____ l. The smelting industry
- _____ m. The lead industry
- _____ n. Any other metal industry
- _____ o. Paint manufacturing
- _____ p. Dye manufacturing
- _____ q. Commercial painting or spray painting
- _____ r. Cotton textiles (carding, spinning, weaving)
- _____ s. Mining
- _____ t. Sand blasting
- _____ u. Brake linings (repair/change)
- _____ v. Foundry
- _____ w. Uranium mining or processing
- _____ x. Farming

Please answer the questions about the type and quantity of foods you eat for a typical day or week. The answers to these questions will help estimate the fat, cholesterol and fiber in your diet.

- 1. How many servings of Grilled meat, chicken or fish do you eat per WEEK?
(grilled meat means meat cooked over charcoal or cooked in a grill)

During the summer _____ servings per week
 During the fall _____ servings per week
 During the winter _____ servings per week
 During the spring _____ servings per week

- 2. How many servings of red meat do you eat during a typical WEEK
_____ servings per WEEK

- 3. How many servings of chicken or fish do you eat during a WEEK?
_____ servings per WEEK

- 4. How many servings of bacon, ham, sausage, or lunch meat do you eat during a WEEK?
_____ servings per WEEK

- 5. How many eggs do you eat during a typical WEEK?
_____ eggs

- 6. How many glasses of milk do you drink during a typical DAY?
_____ glasses per DAY?

- 7. What type of milk do you drink?
 _____ (1) regular (4%)
 _____ (2) low fat (2%)
 _____ (3) skim or skin (1%)
 _____ (4) other _____

- 8. How many cups of coffee or tea do you drink during a DAY?
 _____ cups per day _____ (1) caffeinated
 _____ (2) decaffeinated

9. How many servings of fresh or canned fruits do you eat during a typical DAY?
_____ servings per DAY
10. How many servings of raw, canned or cooked vegetables do you eat during a DAY?
_____ servings per DAY
11. How many servings of cheese (cottage, sharp, american, etc.,) do you eat during a typical DAY?
_____ servings per DAY
12. How many slices of bread, rolls or muffins do you eat during a DAY?
_____ slices or servings per DAY
13. What type of bread do you usually eat?
_____ (1) white
_____ (2) wheat
_____ (3) oatmeal
_____ (4) other _____
14. What kind of spread do you use?
_____ (1) butter
_____ (2) margarine
15. In baking or frying what do you use?
_____ (1) oil
_____ (2) lard
_____ (3) shortening (solid like Crisco)
_____ (4) butter
_____ (5) margarine
_____ (6) pam (spray coating)
16. How many servings of dessert (cookies, cakes, pies, etc.,) do you eat during a typical WEEK?
_____ servings per WEEK
17. How many times during a WEEK do you eat at a fast food restaurant?
_____ times per WEEK

18. When you lived within 5 miles of Fernald did you grow and eat vegetables from a home garden?

- _____ (1) Yes, only fresh vegetables in the summer
- _____ (2) Yes, summer and canned vegetables for winter use
- _____ (3) No

19. Did you buy locally grown fresh vegetables and or fruits from a roadside stand, store, or market within five miles of Fernald and eat them?

- _____ (1) Yes, only fruits and vegetables that were in season
- _____ (2) Yes, in season and canned vegetables and fruit for use during the winter
- _____ (3) No

20. Did you fill this questionnaire out at?

- (1) _____ Home
- (2) _____ Office

Smoker Only

21. Would you participate in free Smoking Cessation Program offered by the Fernald Medical Monitoring Program in the next 6 months?

- (1) _____ Yes
- (2) _____ No

Please provide names and addresses of 3 people who will know where to find you if you were to move.

1. Name: _____
Address: _____

City: _____
State: _____ Zip: _____
Phone Number: _____
Relationship: _____

2. Name: _____
Address: _____

City: _____
State: _____ Zip: _____
Phone Number: _____
Relationship: _____

3. Name: _____
Address: _____

City: _____
State: _____ Zip: _____
Phone Number: _____
Relationship: _____