



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: ⊗ ~~YES~~

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
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When writing dates, please follow this example.

EXAMPLE: June 7, 2004 =

0	6
---	---

 /

0	7
---	---

 /

2	0	0	4
---	---	---	---

(month) (day) (year)

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		
(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)
(hr)			(min)		<input type="radio"/> AM
					<input type="radio"/> PM

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)
(hr)			(min)		<input type="radio"/> AM
					<input type="radio"/> PM

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 →

No

9. What time was the shift?

START TIME:

(mark one)

:
(hr) (min)

AM
 PM

END TIME:

(mark one)

:
(hr) (min)

AM
 PM

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?

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

OR

Didn't go to sleep

Please use a ballpoint pen for this form

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)
(hr) (min) AM
 PM

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.)

AND
OF HOURS # 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?
<input type="radio"/>	<input type="radio"/>	a. Painted wood
<input type="radio"/>	<input type="radio"/>	b. Unfinished wood
<input type="radio"/>	<input type="radio"/>	c. Wood finished in some other way such as a stain, varnish, or polyurethane
<input type="radio"/>	<input type="radio"/>	d. Painted metal
<input type="radio"/>	<input type="radio"/>	e. Unpainted metal
<input type="radio"/>	<input type="radio"/>	f. Painted stucco
<input type="radio"/>	<input type="radio"/>	g. Painted drywall
<input type="radio"/>	<input type="radio"/>	h. Plastic, Formica, laminate, or vinyl
<input type="radio"/>	<input type="radio"/>	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

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 in the past 24 hours.

Yes	No	In the past 24 hours, have you...
<input type="radio"/>	<input type="radio"/>	a. used any form of pesticides or bug repellent?
<input type="radio"/>	<input type="radio"/>	b. used solvents such as nail polish remover or paint thinner?
<input type="radio"/>	<input type="radio"/>	c. used hair spray, hair gel, or hair mousse?
<input type="radio"/>	<input type="radio"/>	d. used overnight cream, lotions, or self-tanners?
<input type="radio"/>	<input type="radio"/>	e. applied nail polish to your own or someone else's nails?
<input type="radio"/>	<input type="radio"/>	f. used perfume or cologne?
<input type="radio"/>	<input type="radio"/>	g. used makeup including foundation, blush, eye makeup, lipstick, etc.?
<input type="radio"/>	<input type="radio"/>	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...
<input type="radio"/>	<input type="radio"/>	a. had any medical procedures that required an IV (intravenous line), not including blood or platelet donation?
<input type="radio"/>	<input type="radio"/>	b. donated blood, not including platelet donation?
<input type="radio"/>	<input type="radio"/>	c. donated platelets, not including blood donation?
<input type="radio"/>	<input type="radio"/>	d. had major dental work, such as root canal, implants, gum surgery, etc.?
<input type="radio"/>	<input type="radio"/>	e. had routine dental work, such as cleanings, fillings, including crowns and x-rays?
<input type="radio"/>	<input type="radio"/>	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.

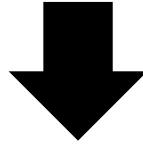
Yes	No	In the past 4 weeks, have you...
<input type="radio"/>	<input type="radio"/>	a. added new furniture?
<input type="radio"/>	<input type="radio"/>	b. added new carpeting?
<input type="radio"/>	<input type="radio"/>	c. added new linoleum or vinyl flooring?
<input type="radio"/>	<input type="radio"/>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

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(month)			(day)			2	0	(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: / /
(month) (day) (year)

