

Questionnaire	Number of Items/Questions	Estimated Time to Administer
<b>Enhanced Health Registry Form</b> – includes scripts and consent/visit information, contact information and extended demographics about smoking and drinking, income, education, exposures, deployment, military service and marital status. Also includes general health information, mental health measures, a brief medical history and self-reported vaccination details.	<ul style="list-style-type: none"> <li>148 total overall questions (includes both pre and post deployment questions)</li> </ul>	20 Minutes

**Enhanced Health Registry Form****INTERVIEWER SCRIPT/PARTICIPANT INSTRUCTIONS**

Hello, my name is [INSERT RESEARCHER/INTERVIEWER NAME] from [INSERT AGENCY/ORGANIZATION NAME]. We are collecting emergency and disaster related health information; this information is important to our research and other affected people. May I read you a consent statement, and then ask you some questions?

- YES [CONTINUE SCRIPT AND QUESTIONNAIRE ADMINISTRATION]  
 NO [GO TO REFUSAL STATEMENT]

**SCRIPT CONTINUED:**

We are getting information from people who have been or are about to be exposed to [INSERT SPECIFIC EVENT OR DISASTER] so that we can collect information about their exposures and health. We will provide health information and offer referrals for services as necessary or as requested. You may also be contacted at a later date to see if you want to join other health, emergency or disaster studies. You are free to enroll in the registry or not; all study activities are completely voluntary. If you choose to enroll, we will ask questions about your health, feelings, experiences with [INSERT SPECIFIC EVENT OR DISASTER], or your experience preparing for [INSERT SPECIFIC EVENT OR DISASTER], employment, places you have been or things in your environment and how to contact you in the future. In total, this will take approximately [INSERT MINUTES/HOURS]. You can choose not to answer any questions that you are not comfortable with. All information will be kept confidential to the extent allowed by law and will be used for research purposes only. Please keep in mind that this study has no bearing on fitness for deployment and results will not be shared with your employer(s).

Is now a good time to conduct the interview?

- Yes [CONTINUE TO REVIEW OF CONSENT FORM]  
 No

When would be a good time to conduct the interview?

Date: \_\_\_ / \_\_\_ / \_\_\_  
Time of Day: \_\_\_ : \_\_\_ [AM/PM]

What is the best telephone number to reach you?

(\_\_\_) \_\_\_ - \_\_\_\_\_

["INTERVIEWER, REVIEW IRB/OMB APPROVED CONSENT FORM WITH PARTICIPANT. BE SURE THAT ALL SIGNATURES, DATES AND CHECKBOXES ARE COMPLETED AND THAT THE PARTICIPANT'S QUESTIONS AND CONCERNS HAVE BEEN ADDRESSED BEFORE ADMINISTERING ANY QUESTIONNAIRES OR COLLECTING BIOLOGICAL SPECIMENS"]

**REFUSAL STATEMENT:**

Ok, thank you for your time. If you change your mind about participating, please contact [INSERT AGENCY/ORGANIZATION NAME AND CONTACT INFORMATION] for study details and enrollment information.

**Study Visit Information:** (Source: ATSDR Rapid Registry Form/NIEHS GuLF Oil Spill Study)

[INTERVIEWER NOTE: THIS SECTION TO BE COMPLETED BY INTERVIEWER ONLY]

[PROGRAMMER NOTE: AUTO-TIME STAMP AND PRE-POPULATE]

DID THE PARTICIPANT CONSENT TO THE RAPIDD BASELINE VISIT?

YES

NO

[PROGRAMMER NOTE: IF "NO", DISPLAY MESSAGE= "RECORD CONSENT REFUSAL REASON IF PROVIDED AND END RAPIDD BASELINE REGISTRY BASIC CORE FORM ADMINISTRATION."]

[INTERVIEWER NOTE: IF "NO" RECORD CONSENT REFUSAL REASON IF PROVIDED AND END RAPIDD BASELINE REGISTRY BASIC CORE FORM ADMINISTRATION.]

IF "NO", RECORD REASON(S) FOR CONSENT REFUSAL:

[FREE TEXT FIELD]

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NO REFUSAL REASON GIVEN/OBTAINED

[PROGRAMMER NOTE: IF "NO" TO CONSENT, BLOCK ALL FURTHER DATA ENTRY FOR THIS PAGE "STUDY VISIT INFORMATION."]

DISASTER EVENT CODE(S): |\_\_|\_\_|\_\_| [01 – HURRICANE, 02 – TORNADO, 03 – FLOOD ETC.]

DISASTER NAME AND DESCRIPTION: (i.e. Hurricane Katrina, World Trade Center 9/11, 2014 Oso Mudslide)

[FREE TEXT]

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ENTER CONSENT DATE

|\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_| [MM-DD-YYYY]

RECORD CONSENT VERSION #:

|\_\_|\_\_|\_\_|\_\_|

[PROGRAMMER NOTE: ADD LOGIC CHECK FOR DATA ENTRY OF CONSENT VERSION #]

SITE/LOCATION[FREE TEXT] |\_\_\_\_\_|

INTERVIEWER INITIALS/ID: |\_\_|\_\_|\_\_|

PARTICIPANT UNIQUE ID: |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|

DATE OF BASELINE VISIT: |\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_| [MM-DD-YYYY]

TIME BASELINE VISIT STARTED - |\_\_|\_\_:|\_\_| [HH: MM] |\_\_|\_\_| [AM/PM]

TIME BASELINE VISIT COMPLETED - |\_\_|\_\_:|\_\_| [HH: MM] |\_\_|\_\_| [AM/PM]





[PROGRAMMER NOTE: IF ANSWER CHOICE "YES" IS SELECTED FOR QUESTION 13, DO NOT DISPLAY QUESTION 16 - IF QUESTION 16 IS PROGRAMMED TO BE VISIBLE, DISPLAY AS FOLLOWS]

16. What is (his/her) **home** address? [FREE TEXT] (ONLY FILL IN ADDRESS INFORMATION BELOW IF YOU ANSWERED "YES" TO QUESTION 12. IF YOU ANSWERED "YES" TO QUESTION 13, PLACE A MARK IN THE CHECKBOX BELOW "SAME AS MY ADDRESS")

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ [Enter state abbreviation]

Zip \_\_\_\_\_

- Don't Know
- Refused
- Same as my address (ONLY SELECT THIS CHECKBOX IF YOU ANSWERED "YES" TO QUESTION 13)

17. What is the **best** telephone number to reach him/her?

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

- None
- Same as my/participant home phone
- Don't Know
- Refused

18. Is this a home, work, or cell/mobile number?

- Home
- Work
- Cell/mobile
- Other
- Don't know
- Refused

19. Does (he/she) have an **email** address?

- Yes, specify (i.e. JohnDoe@aol.com) [FREE TEXT]: \_\_\_\_\_
- No
- Don't Know
- Refused

**Demographics and Sociological Factors:** (Sources: PhenX toolkit, NHANES, EPA NHEXAS)

The following questions gather some basic information about you and your lifestyle. This information is often used in scientific studies to compare groups of people who are similar. Please remember that all of the data you provide is held in strict confidence.

20. What is your employment status? When applicable, check all that apply. (Source: WTC Adult Survey Wave 3 answer choices/ ATSDR RRR Survey question – modified)

- Employed for **full-time** wages
- Employed for **part-time** wages
- Unable to work because of health
- Self-employed
- Out of work for 1 year or more
- Out of work for less than 1 year
- Retired
- On maternity or parental leave
- Looking for work
- Student
- Home maker
- Volunteer
- Other, specify: [FREE TEXT] \_\_\_\_\_
- Refused

21. What is the highest grade or level of school you have completed or the highest degree you have received? (Source: NHANES 2013-2014)

- Never attended/kindergarten only
- 1st grade
- 2nd grade
- 3rd grade
- 4th grade
- 5th grade
- 6th grade
- 7th grade
- 8th grade
- 9th grade
- 10th grade
- 11th grade
- 12th grade, no diploma
- High school graduate
- GED or equivalent
- Some college, no degree
- Associate Degree: Occupational, Technical, or Vocational Program
- Associate Degree: Academic Program
- Bachelor's Degree (example: BA, AB, BS, BBA)
- Master's Degree (example: MA, MS, MENG, MED, MBA)
- Professional School Degree (example: MD, DDS, JD)
- Doctoral Degree (example: PhD, EDD)
- Other, Specify [FREE TEXT]: \_\_\_\_\_
- Don't Know/Unsure
- Refused

22. What is your **total gross annual household** income **before** taxes? Please include **all sources** of income. This could include income from other household members, your spouse or partner's income, wages, tips, salary, pension, retirement, social security benefits, child support, alimony, outside aid from friends or relatives, workers compensation, VA payments or unemployment compensation to name a few examples. (Source: NHEXAS)

- Less than \$9,999
- \$ 10,000 - \$ 19,999
- \$ 20,000 - \$ 29,999
- \$ 30,000 - \$ 39,999
- \$ 40,000 - \$ 49,999
- \$ 50,000 - \$ 74,999
- \$ 75,000 - \$ 99,999
- \$100,000 - \$149,999
- Over \$150,000
- Don't Know
- Refused

23. Are you now married, widowed, divorced, separated, never married or living with a partner? (Source: NHANES, 2013-2014)

- Married
- Widowed
- Divorced
- Separated
- Never married/Single
- Living with partner
- Refused

24. What race or race(s) do you consider yourself to be? Check all that apply. (Source: NHANES, 2013-2014)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White
- Other, specify [FREE TEXT]: \_\_\_\_\_
- Don't Know
- Refused

25. Do you consider yourself to be of Hispanic, Latin or Spanish origin? (Source: EPA NHEXAS/NHANES 2013-2014)

- Yes
- No
- Don't Know
- Refused

26. Have you ever served on active duty in the **U.S. Armed Forces, military Reserves, or National Guard**? (Active duty does **not** include training for the Reserves or National Guard, but **does** include activation, for service in the U.S. or in a foreign country, in support of military or humanitarian operations.) (Source: NHANES, 2013-2014 – modified answer choice)

- Yes, currently enlisted [GO TO QUESTION 27]
- Yes, retired/discharged [GOT TO QUESTION 27]
- No [GO TO QUESTION 29]
- Don't Know [GO TO QUESTION 29]
- Refused [GO TO QUESTION 29]

[PROGRAMMER NOTE: IF "NO", "DON'T KNOW" OR "REFUSED" SELECTED, SUPPRESS/HIDE QUESTIONS 27-28]

27. Please indicate the service branch you are/were in: (Source: DOD)

- Air Force  
 Army  
 Navy  
 Marine Corps  
 National Guard  
 Civilian Expeditionary Workforce (CEW)  
 USPHS  
 Other Defense Agency specify: [FREE TEXT] \_\_\_\_\_  
 Don't Know  
 Refused

28. Please indicate the appropriate component for your military service: (Source: DOD)

- Active duty  
 National Guard  
 Reserves  
 Civilian Government Employee  
 Other, specify: [FREE TEXT] \_\_\_\_\_  
 Don't Know  
 Refused

29. Do you drink alcohol in **any** form?

- Yes  
 No [GO TO QUESTION 32]  
 Don't Know  
 Refused

30. During the **past month**, how many **days per week** did you drink? (Source: EPR)

Enter number of days per week:

- |\_|\_|\_|\_|  
 0 or none  
 Don't Know  
 Refused

31. How many **years** have you drank alcohol regularly? (Source: EPR)

Enter number of years:

- |\_|\_|\_|\_|  
 Less than 1 year  
 Don't Know  
 Refused

32. Have you **ever in your life** smoked tobacco products or used smokeless tobacco products? (Source: EPA NHEXAS)

- Yes  
 No [GO TO QUESTION 34]  
 Don't Know [GO TO QUESTION 34]  
 Refused [GO TO QUESTION 34]

33. Do you **currently** smoke tobacco products or use smokeless tobacco products? (Source: EPA NHEXAS)

- Yes  
 No  
 Refused

34. Are you ever exposed to tobacco smoke at home or in an indoor workspace? (Source: modified from EPR)

- Yes
- No
- Don't Know
- Refused

**General Health**

The following questions ask about your overall health and medical history. Please answer each question to the best of your ability.

35. Which of these describes your health, **in general!**? (Source: ERHMS)

- Excellent
- Very Good
- Good
- Fair
- Poor
- Don't Know
- Refused

36. Overall, how would you rate your health during the **past month**? (Source: DOD)

- Excellent
- Very Good
- Good
- Fair
- Poor
- Don't Know
- Refused

37. Compared to **five years ago** how would you rate your health **in general now**? (Source: DOD/EPR)

- Much better now than before
- Somewhat better now than before
- About the same as before
- Somewhat worse now than before. Please explain: [FREE TEXT] \_\_\_\_\_
- Much worse now than before. Please explain: [FREE TEXT] \_\_\_\_\_
- Don't Know
- Refused

38. How would you rate your **current** physical fitness level? (E Source: RHMS)

- Excellent
- Very Good
- Good
- Fair
- Poor
- Don't Know
- Refused

39. How is your hearing? (ERHMS)

- Excellent
- Good
- Fair
- Poor
- Don't Know
- Refused

The next few questions ask about illnesses you may have had and the kinds of medicines you may have used. Have you ever been told by a **doctor or other health care provider** that you **have or had any** of the following medical conditions? Fill out the table below, selecting the appropriate response. (Source: ACE, Health History Module F)

Medical Condition	Diagnosed?
40. Allergies?	<input type="checkbox"/> Yes (Please specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
41. Asthma?	<input type="checkbox"/> Yes (Please specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
42. Diabetes?	<input type="checkbox"/> Yes (Please specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
43. High Blood Pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
44. Chronic Obstructive Pulmonary Disease (COPD) or Emphysema?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
45. Heart Disease?	<input type="checkbox"/> Yes (Please specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
46. Physical disability that hinders mobility?	<input type="checkbox"/> Yes (Please specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
47. Psychological condition such as anxiety, depression or dependence disorder?	<input type="checkbox"/> Yes (Please specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure/Don't Know <input type="checkbox"/> Refused
48. Cancer?	<input type="checkbox"/> Yes (Please specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
49. Immune disorders such as lupus, rheumatoid arthritis, or HIV?	<input type="checkbox"/> Yes (Please specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
50. Neurological conditions such as Parkinson's disease or multiple sclerosis?	<input type="checkbox"/> Yes (Please specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
51. Any other medical conditions?	<input type="checkbox"/> Yes (Please specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused

52. Are you currently taking **any** medicines? This includes, but is not limited to, medicines prescribed by a health care provider, herbs, vitamins or supplements, creams, suppositories, patches, pills, shots/injections, liquids, or inhalers and those medications you might have gotten **without** a prescription from stores, pharmacies, friends, or relatives. (Source: Modified ACE question to include medical language from NHANES, 2011)

- Yes
- No [GO TO QUESTION 54]
- Don't Know [GO TO QUESTION 54]
- Refused [GO TO QUESTION 54]

[PROGRAMMER NOTE: IF "NO", "DON'T KNOW" OR "REFUSED" SELECTED, DO NOT DISPLAY QUESTION 53 - THE MEDICATION LIST]

53. What medicines are you taking? Please include **all prescription and non-prescription** medications. If you do not know the name of the medication, please list what the medicine is for. If you are currently taking **more than 10 medications** of **any** kind, please check the box below, in addition to completing the chart. There are only 10 spaces for you to list medications you may currently be using. If you run out of spaces, that's OK. Just make sure you check the box below and then you can continue to the next section.

I am currently taking **more than 10** medications

[PROGRAMMER NOTE: LOOP/REPEAT QUESTIONS IN MEDICATION TABLE AND FREE TEXT DATA ENTRY FOR MULTIPLE MEDICATIONS AND IN INSTANCES WHERE THERE ARE MORE THAN 10 MEDICINES USED]

Name of Medication(s) – List Here [FREE TEXT]	What do you take this medication for? [FREE TEXT]
a. [FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know	[FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know
b. [FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know	[FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know
c. [FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know	[FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know
d. [FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know	[FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know
e. [FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know	[FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know
f. [FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know	[FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know
g. [FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know	[FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know
h. [FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know	[FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know
i. [FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know	[FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know
j. [FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know	[FREE TEXT] <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know

**Vaccinations**

The next few questions are about vaccinations you may have received. Please answer each question in as much detail as possible and to the best of your ability. In this section, you are asked for the specific dates when you received your vaccination(s). If you cannot remember the exact date of a vaccination or series of vaccinations, give your best estimate and try to provide any information you can remember, even if it is not complete.

[PROGRAMMER NOTE: ALLOW FOR FREE TEXT/PARTIAL DATA ENTRY FOR DATES]

54. Have you received the tetanus/diphtheria (Tdap) vaccine?

- Yes
- No
- Don't know
- Refused

54a. What was the data of your last tetanus/diphtheria (Tdap) vaccination?

\_\_\_ / \_\_\_ / \_\_\_\_\_ [MM/DD/YYYY]

55. Have you received the Hepatitis B vaccine?

- Yes
- No
- Don't know
- Refused

55a. What was the data of your last Hepatitis B vaccination series?

\_\_\_ / \_\_\_ / \_\_\_\_\_ [MM/DD/YYYY]

56. Have you received the Influenza (Pandemic/Seasonal Flu) vaccine?

- Yes
- No
- Don't know
- Refused

56a. What was the data of your last Influenza (Pandemic/Seasonal Flu) vaccination?

\_\_\_ / \_\_\_ / \_\_\_\_\_ [MM/DD/YYYY]

The next few questions will ask about your thoughts, feelings and behaviors and how an event may have impacted your emotions. Please answer each question to the best of your ability. There are no right or wrong answers.

Over the last **2 weeks**, how often have you been bothered by any of the following problems?

Statement	Not at all	Several days	More than half the days	Nearly every day	Don't Know	Refused
57. Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
58. Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
59. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
60. Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
61. Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99

Statement	Not at all	Several days	More than half the days	Nearly every day	Don't Know	Refused
62. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
63. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
64. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
65. Thoughts that you would be better off dead, or of hurting yourself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99

66. If you checked off that you were bothered by any of the problems listed, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult
- Don't Know
- Refused

Over the last **2 weeks**, how often have you been bothered by the following problems?

Statement	Not at all	Several days	Over half the days	Nearly everyday	Don't know	Refused
67. Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
68. Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
69. Worrying too much about different things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
70. Trouble relaxing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
71. Being so restless that it's hard to sit still	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
72. Becoming easily annoyed or irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99
73. Feeling afraid as if something awful might happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 88	<input type="checkbox"/> 99

74. If you checked off that you were bothered by any of the problems listed, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult
- Don't Know
- Refused

**PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY:**

Your involvement in [INSERT DISASTER EVENT] may have had an impact on you. The next few questions will ask specifically about your thoughts, feelings and experiences of [INSERT DISASTER EVENT]. **If you have not yet been or were not deployed to** [INSERT DISASTER EVENT], think about a time in your life when something happened that you felt was very stressful, upsetting, disturbing, hurtful, traumatic, threatening and or frightening in some way. Although you may have had many experiences that fit this description, try to answer the following questions based only on **one** incident.

Most everyone has been through a stressful event in his or her life. When the event, or series of events, causes a lot of stress, it is called a traumatic event (Source: CDC). Traumatic events are marked by a sense of horror, helplessness, serious injury, or the threat of serious injury or death (Source: CDC). Traumatic events affect survivors, rescue workers, and the friends and relatives of victims who may have been involved (CDC). They may also have an impact on people who have seen the event either firsthand or through the media (Source: CDC). For example, a traumatic event could be **experiencing** or **witnessing** directly or indirectly, the death of a loved one or a pet, violence – such as a fight or a shooting, a house fire or burglary, a car accident, an attack such as the World Trade Center or Boston Marathon Bombing, a natural disaster such as a hurricane or tornado, going through a divorce/break-up or being diagnosed with a medical condition or disease that you see as life changing.

Remember, **these are only examples**. What one person finds traumatic, hurtful, upsetting or frightening, may not be to someone else. Please use any **one** event you feel would work best for you in answering the questions. If you have **never** experienced a traumatic event - something that made you feel afraid, helpless, threatened or upset, choose "I've never experienced a traumatic event" below.

I've never experienced a traumatic event [GO TO QUESTION 92]

[PROGRAMMER NOTE: DON'T DISPLAY QUESTIONS 75-91 IF "I'VE NEVER EXPERIENCED A TRAUMATIC EVENT" SELECTED].

**Questions about the Effects of Traumatic Events:** Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please select the response that reflects how much you have been bothered by that problem in the last **month**.

75. Repeated, disturbing memories, thoughts, or images, of the stressful experience?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

76. Repeated, disturbing dreams of the stressful experience?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

77. Suddenly acting or feeling as if the stressful experience was happening again (as if you were reliving it)?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

78. Feeling very upset when something reminded you of the stressful experience?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

79. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the stressful experience?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

80. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

81. Avoiding activities or situations because they reminded you of the stressful experience?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

82. Trouble remembering important parts of the stressful experience?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

83. Loss of interest in activities that you used to enjoy?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

84. Feeling distant or cut off from other people?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

85. Feeling emotionally numb or being unable to have loving feelings for those close to you?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

86. Feeling as if your future will somehow be cut short?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

87. Trouble falling or staying asleep?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

88. Feeling irritable or having angry outbursts?

- Not at all
- A little bit
- Very much
- Don't Know
- Refused

89. Having difficulty concentrating?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

90. Being "super-alert" or watchful or on guard?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

91. Feeling jumpy or easily startled?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- Don't know
- Refused

**Deployment Information** (Sources: ERHMS Pre-Deployment Questionnaire, ATSDR Rapid Registry Form, Department of Defense/Department of Homeland Security Post Deployment Form)

The next few sections contain questions about deployments and exposure history. Answer each of these questions based on your knowledge and experiences. Please attempt to answer each question in as much detail as possible and to the best of your ability. For questions that may not apply to you, there will be instructions for when to skip those questions and where to go next.

92. Are you preparing to respond to [INSERT DISASTER EVENT], recently returning from responding to [INSERT DISASTER EVENT] or currently in training to respond to [INSERT DISASTER EVENT]?

- Preparing to respond to an event [GO TO QUESTION 93]
- Recently returning from an event [GO TO QUESTION 114]
- Currently in training to prepare for an event [GO TO QUESTION 93]
- Other, specify [free text] \_\_\_\_\_
- Refused [END SURVEY]

[PROGRAMMER NOTE: IF "PREPARING TO RESPOND" OR "CURRENTLY IN TRAINING" ARE SELECTED, DISPLAY ONLY PRE-DEPLOYMENT QUESTIONS 93 -114, BUT DO NOT DISPLAY POST-DEPLOYMENT QUESTIONS FOR DATA ENTRY. IF "RETURNING FROM AN EVENT" SELECTED, DISPLAY POST DEPLOYMENT QUESTIONS 114-148.]

### Pre-Deployment Information

We would like to get as much information as possible from you about your upcoming deployment for/to [INSERT DISASTER EVENT].

93. Will you be exposed to [INSERT DISASTER EVENT] as: [Check all that apply] (Source: ATSDR Rapid Registry form modified)

- A First responder or rescue worker (i.e. Firefighter, Police Officer, EMS)
- A Government official – Civilian or Military (i.e. State, Federal, County, City, Branch of Military)
- A Clean-up or disaster worker (i.e. Hazmat, Search and Rescue)
- Part of a non-governmental organization or as a site volunteer (i.e. the Red Cross)
- Other, specify [FREE TEXT] \_\_\_\_\_
- Don't Know
- Refused

94. Please provide your deployment site/job location (Modified ERHMS for time tense)

[FREE TEXT]: \_\_\_\_\_

- Don't Know  
 Refused

95. What is your **anticipated** date of deployment? (Modified ERHMS for time tense)

|\_|\_| - |\_|\_| - |\_|\_|\_|\_|\_|

[MM-DD-YYYY]

- Don't know  
 Refused

96. What is your **anticipated** duration of deployment? (Modified EHRMS pre-deployment question; added answer choices)

Enter a number **AND** select a unit of time (i.e. week, month, day, years etc.)

|\_|\_|\_|

- Hour(s)  
 Day(s)  
 Week(s)  
 Month(s)  
 Year(s)  
 Don't Know  
 Refused

97. What will be your **anticipated** duties during deployment? (Check all that apply) (Source: DHS)

- Search & Rescue  
 Law Enforcement/Security  
 Safety/Health  
 Recovery  
 Immigration Enforcement duties  
 Operations  
 Peer Support/Critical Incident Stress Management  
 Medical/Health Care  
 Other, specify: [FREE TEXT] \_\_\_\_\_  
 Refused

98. Will your work responsibilities involve potential exposure to hazardous substances? (Modified ERHMS for time tense)

Yes, if known, specify which substances [FREE TEXT]: \_\_\_\_\_

- No  
 Don't Know  
 Refused

99. Will there be a need for Personal Protective Equipment (PPE) use? (ERHMS, modified)

- Yes  
 No [GO TO QUESTION 102]  
 Don't Know [GO TO QUESTION 102]  
 Refused [GO TO QUESTION 102]

100. If yes, what type of Personal Protective Equipment (PPE) will you wear? Check all that apply. (Source: DHS)

Respirator - Please print type (e.g., disposable mask, half face reusable, full face, PAPR, SCBA etc.)

[FREE TEXT] \_\_\_\_\_

- Face Shield  
 Gloves  
 Work coveralls (e.g., Carhartt, Dickie's)

- Tyvek/Tychem (A full body suit made from polyethylene fibers that protect you from possibly harmful chemicals and vapors.)
- Slicker Suit (Rain)
- Insect repellent applied to skin (i.e. DEET)
- Pesticide treated clothing/uniforms
- Steel toed construction shoes
- Rubber Boots/Waders
- Goggles / Glasses (**does not** include non-commercial sunglasses or prescription eyeglasses)
- Hearing Protection (i.e. ear plugs/muffs)
- Hard hat
- Other, specify: [FREE TEXT] \_\_\_\_\_

101. If you are required to wear a respirator, will you receive a medical evaluation and be fit tested prior to wearing the respirator?

- Yes, I will be fit tested **and** will receive a medical evaluation
- Yes, I will be fit tested **only**
- Yes, I will receive a medical evaluation **only**
- No, I will not be fit tested or receive a medical evaluation
- Don't Know
- Refused

102. How many **total** deployments have you had in the past **5 years**? (Source: DOD)

- 0 or none
- 1
- 2
- 3
- 4
- 5 or more
- Don't Know
- Refused

103. Do you believe that you received adequate (enough) pre-incident training for the tasks you will be asked to perform? (Source: ERHMS)

- Yes
- No
- Don't Know
- Refused

**Pre-Deployment Exposures and Past History of Exposure** (Source: ERHMS)

In your **job**, have you **ever** been exposed to any of the following chemicals or work conditions?

<b>Chemical/Condition</b>	<b>Select Answer Choice:</b>
104.Dust?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
105.Fumes?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
106.Gases?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
107.Carbon Monoxide?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
108.Cement Dust?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
109.Chemicals/Solvents?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
110.Blood/Body Fluids?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
111.Sewage (Raw/Untreated)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
112.Smoke/Fire?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
113.Other exposure? Specify [FREE TEXT] _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused

**[STOP! END PRE-DEPLOYMENT QUESTIONS HERE. IF YOU HAVE NOT YET BEEN DEPLOYED TO {INSERT DISASTER EVENT} OR ARE IN TRAINING, THE QUESTIONNAIRE ENDS HERE AND YOU ARE FINISHED]**

**Post-Deployment Information**

The next few sections contain questions about deployments and exposure history. Answer each of these questions based on your knowledge and experiences. Please attempt to answer each question in as much detail as possible and to the best of your ability. For questions that may not apply to you, there will be instructions for when to skip those questions and where to go next.

114.Were you exposed to [INSERT DISASTER EVENT]as: [Check all that apply] (Source: Modified ATSDR Rapid Registry form question)

- A First responder or rescue worker (i.e. Firefighter, Police Officer, EMS)
- A Government official – Civilian or Military (i.e. State, Federal, County, City, Branch of Military)
- A Clean-up or disaster worker (i.e. Hazmat, Search and Rescue)
- Part of a non-governmental organization or as a site volunteer (i.e. the Red Cross)
- Other, specify [FREE TEXT] \_\_\_\_\_
- Don't Know
- Refused

115.Please provide your deployment site/job location (Source: Modified ERHMS for time tense)

[FREE TEXT]: \_\_\_\_\_

- Don't Know
- Refused

116.What was the date of your deployment? (Source: Modified ERHMS for time tense)

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

[MM-DD-YYYY]

- Don't know
- Refused

117.What was the duration of your deployment? (Source: Modified EHRMS pre-deployment question; added answer choices)

Enter the number **AND** select the unit of time (i.e. week, month, day, years etc.)

\_\_\_\_

- Hour(s)
- Day(s)
- Week(s)

- Month(s)
- Year(s)
- Don't Know
- Refused

118. What were your duties during deployment? (Check all that apply) (Source: DHS)

- Search & Rescue
- Law Enforcement/Security
- Safety/Health
- Recovery
- Immigration Enforcement duties
- Operations
- Peer Support/Critical Incident Stress Management
- Medical/Health Care
- Other, specify [FREE TEXT]: \_\_\_\_\_
- Refused

119. Did your work responsibilities involve potential exposure to hazardous substances? (Source: Modified ERHMS for time tense)

- Yes, if known, specify which substances [FREE TEXT]: \_\_\_\_\_
- No
- Don't Know
- Refused

120. Was there a need for Personal Protective Equipment (PPE) use? (Source: ERHMS, modified)

- Yes
- No [GO TO QUESTION 123]
- Don't Know [GO TO QUESTION 123]
- Refused [GO TO QUESTION 123]

121. If yes, what type of Personal Protective Equipment (PPE) did you wear? Check all that apply. (Source: DHS/Gulf On Shore exposure Assessment)

- Respirator - Please print type (e.g., disposable mask, half face reusable, full face, PAPR, SCBA etc.) [FREE TEXT] \_\_\_\_\_
- Face Shield
- Gloves
- Coveralls (cloth and/or disposable)
- Tyvek/Tychem (A full body suit made from polyethylene fibers that protect you from possibly harmful chemicals and vapors.)
- Slicker Suit (Rain)
- Insect repellent applied to skin (i.e. DEET)
- Pesticide treated clothing/uniforms
- Steel toed construction shoes
- Rubber Boots/Waders
- Goggles / Glasses (**does not** include non-commercial sunglasses or prescription eyeglasses)
- Hearing Protection (i.e. ear plugs/muffs)
- Hard hat
- Other, specify: [FREE TEXT] \_\_\_\_\_
- Don't Know
- Refused

[PROGRAMMER NOTE: ONLY DISPLAY QUESTION 122 IF "RESPIRATOR" ANSWER CHOICE IS SELECTED IN QUESTION 121].

122. If you were required to wear a respirator, did you receive a medical evaluation and fit test prior to wearing the respirator?

- Yes, I was fit tested **and** received a medical evaluation
- Yes, I was fit tested **only**
- Yes, I received a medical evaluation **only**
- No, I was not fit tested and did not receive a medical evaluation
- Don't Know
- Refused

123. Total number of deployments in the past **5 years**? (Source: DOD)

- 0 or none
- 1
- 2
- 3
- 4
- 5 or more
- Don't Know
- Refused

124. Do you believe that you received adequate (enough) pre-incident training for the tasks you were asked to perform? (Source: ERHMS)

- Yes
- No
- Don't Know
- Refused

**Post-Deployment Exposure Information** (Source: ATSDR RRR)

The next few questions ask about activities you may have been involved in, locations you may have visited and exposures that may have occurred or that you may have experienced **during or after** your deployment for/to [INSERT RELEVANT DISASTER EVENT].

125. Were you near or at the [DISASTER EVENT] site when the event started?

- Yes
- No [GO TO QUESTION 131]
- Don't Know [GO TO QUESTION 131]
- Refused [GO TO QUESTION 131]

[PROGRAMMER NOTE: IF "NO," "DON'T KNOW" OR "REFUSED" ARE SELECTED, SKIP TO QUESTION 131]

126. At the **start** of the [DISASTER EVENT] on [DATE] at [TIME], at what address were you? [FREE TEXT]

- 
- Don't Know       Refused

127. What was the name of nearest building to you? [FREE TEXT]

- 
- Don't Know       Refused

128. What was the nearest intersection? [FREE TEXT]

- 
- Don't Know       Refused

129. What was the nearest landmark? [FREE TEXT]

- 
- Don't Know       Refused

130. At the start of the [DISASTER EVENT], were you: (check all that apply):

- Inside a building or structure
- Inside a car or other vehicle
- Outside
- At some other location, specify: [FREE TEXT]

- 
- Don't Know       Refused

131. As a result of the [DISASTER EVENT], did you get injured or become ill?

- Yes, describe: [FREE TEXT]

- 
- No
  - Don't Know
  - Refused

132. Did you require medical attention **during** your deployment? ( Source: DHS)

- Yes, describe: [FREE TEXT]

- 
- No/Not applicable
  - Don't Know
  - Refused

133. Before the [DISASTER EVENT], did you have any of the following conditions? (check all that apply)

- Chronic illness
- Physical disability
- Other disability, specify: [FREE TEXT] \_\_\_\_\_
- None [GO TO QUESTION 135]
- Don't Know [GOT TO QUESTION 135]
- Refused [GO TO QUESTION 135]

134. Please describe your condition: [FREE TEXT]

- 
- Refused

**Post-Deployment Exposure Information (Continued):**

The next few questions will ask about a chemical or work condition that you may have been exposed to **during your deployment** to [INSERT DISASTER EVENT]. To the best of your ability, please answer in as much detail as possible about your experience(s). DK = Don't Know.

Which of the following chemicals and or work conditions applied to you?	Answer choice(s)	What was the length of your exposure to this chemical or condition? Please report the number of days.	What type of protection did you use with this exposure? And what percentage (%) of the time did you wear protective equipment with this exposure? (e.g., gloves – 50%, respirator - 100%)
135. Dust?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused	_ _ _ _ _  Days <input type="checkbox"/> DK <input type="checkbox"/> Refused	<input type="checkbox"/> DK <input type="checkbox"/> Refused
136. Fumes?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused	_ _ _ _ _  Days <input type="checkbox"/> DK <input type="checkbox"/> Refused	<input type="checkbox"/> DK <input type="checkbox"/> Refused
137. Gases?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused	_ _ _ _ _  Days <input type="checkbox"/> DK <input type="checkbox"/> Refused	<input type="checkbox"/> DK <input type="checkbox"/> Refused
138. Carbon Monoxide?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused	_ _ _ _ _  Days <input type="checkbox"/> DK <input type="checkbox"/> Refused	<input type="checkbox"/> DK <input type="checkbox"/> Refused
139. Cement Dust?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused	_ _ _ _ _  Days <input type="checkbox"/> DK <input type="checkbox"/> Refused	<input type="checkbox"/> DK <input type="checkbox"/> Refused
140. Chemicals/Solvents?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused	_ _ _ _ _  Days <input type="checkbox"/> DK <input type="checkbox"/> Refused	<input type="checkbox"/> DK <input type="checkbox"/> Refused
141. Blood/Body Fluids?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused	_ _ _ _ _  Days <input type="checkbox"/> DK <input type="checkbox"/> Refused	<input type="checkbox"/> DK <input type="checkbox"/> Refused
142. Sewage (Raw/Untreated)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused	_ _ _ _ _  Days <input type="checkbox"/> DK <input type="checkbox"/> Refused	<input type="checkbox"/> DK <input type="checkbox"/> Refused
143. Smoke/Fire?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused	_ _ _ _ _  Days <input type="checkbox"/> DK <input type="checkbox"/> Refused	<input type="checkbox"/> DK <input type="checkbox"/> Refused
144. Other exposure? Specify, [FREE TEXT] _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused <input type="checkbox"/> NA	_ _ _ _ _  Days <input type="checkbox"/> DK <input type="checkbox"/> Refused	<input type="checkbox"/> DK <input type="checkbox"/> Refused

145. Did you work in close proximity to flood waters? (Source: DHS)  
Yes: How many hours **on average** did you work in close proximity to flood waters [HH]? |\_|\_|. How many days [DDD]? |\_|\_|\_|  
No/Not applicable  
Don't Know  
Refused

146. Did you sustain any skin wounds? (Source: DHS)

Yes, specify or describe: [FREE TEXT]

---

No/Not applicable

Don't Know

Refused

147. Did you experience any bites (Insects, snakes, dogs, other)? (Source: DHS)

Yes, specify or describe: [FREE TEXT]

---

No/Not applicable

Don't Know

Refused

148. Did you handle deceased persons? (Source: DHS)

Yes, what type of personal protective equipment (PPE) did you wear? [FREE TEXT] \_\_\_\_\_

No/Not applicable

Don't Know

Refused

**[END RAPIDD BASELINE QUESTIONNAIRE ENHANCED REGISTRY CORE FORM]**