

# A Survey of Asthma in Health Professionals

You have been randomly selected from among your licensed Texas colleagues. All answers are confidential.

START HERE

## Trouble Breathing

Questions 1 through 3 ask you about trouble breathing *EVER IN YOUR LIFE*

1. Have you ever had trouble with your breathing?  
(Mark an X for the single best answer)

- Yes —————→ Go to Questions 1.1 and 1.2  
 No —————→ Go to Question 2  
 Don't Know —————→ Go to Question 2

1.1 If YES, what kind of troubled breathing did you have?

- Continuously, as if breathing is not quite right  
 Repeatedly, however gets completely better  
 Only rarely

1.2 Was your troubled breathing brought on by your work environment?

- Yes  
 No  
 Don't Know

2. Have you ever had COPD or emphysema confirmed by a doctor?

- Yes  
 No  
 Don't Know

3. Have you ever had asthma? (Mark an X for the single best answer)

- Yes  
 No —————→ Go to Question 7  
 Don't Know —————→ Go to Question 7

3.1 If YES, has your asthma been confirmed by a doctor?

- Yes  
 No —————→ Go to Question 7  
 Don't Know —————→ Go to Question 7

3.1.1 If YES, at what age was your asthma confirmed by a doctor?

\_\_\_\_\_ YEARS OLD

3.1.2 If YES, when your asthma was confirmed by a doctor, were you...?

- Not working  
 Working as a healthcare professional  
 Working, but not as a healthcare professional

↓  
Please specify your job:

\_\_\_\_\_

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For Office use Only

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## Asthma

*Questions 4 and 5 ask you about asthma in THE LAST 12 MONTHS*

4. Have you had an attack/episode of asthma in the last 12 months? (Mark an X for the single best answer)

- Yes  
 No \_\_\_\_\_ → Go to Question 5  
 Don't Know \_\_\_\_\_ → Go to Question 5

4.1 If YES, how many attacks/episodes of asthma have you had in the last 12 months? (Enter approximate number of asthma attacks)

\_\_\_\_\_ ATTACKS

4.2 Have you had an attack/episode of asthma while you were at work in the last 12 months?

- Yes  
 No \_\_\_\_\_ → Go to Question 5  
 Don't Know \_\_\_\_\_ → Go to Question 5

4.2.1 If YES, do you know what triggered the last attack/episode of asthma while you were at work?

- Yes  
 No \_\_\_\_\_ → Go to Question 5

4.2.1.a If YES, what was the trigger?

\_\_\_\_\_

5. On average, how often do/did you take any medications for asthma, including inhalers, aerosols or tablets in the last 12 months?

- Daily  
 Weekly  
 Monthly  
 Rarely (less than once a month)  
 Never

## Unplanned Care for Asthma

*Question 6 asks you about unplanned care for your asthma in THE LAST 12 MONTHS*

6.1 Have you increased your use of fast-acting (or rescue) bronchodilators or inhaled steroids on a short-term basis for two consecutive days or longer?

- Yes  
 No

6.2 Have you increased your use of oral steroids on a short-term basis for two consecutive days or longer?

- Yes  
 No

6.3 Have you been treated with any oral or IV steroids (e.g., prednisone, 7-day steroid pack)?

- Yes  
 No

6.4 Have you had any urgent treatment at your doctor's office?

- Yes  
 No

6.5 Have you had any treatment in an emergency room?

- Yes  
 No

6.6 Have you been hospitalized (e.g., overnight or longer)?

- Yes  
 No

## Wheezing, Whistling or Shortness of Breath

*Questions 7 through 9 ask you about your breathing in THE LAST 12 MONTHS*

7. Have you had wheezing or whistling in your chest in the last 12 months? (Mark an X for the single best answer)
- Yes —————→ *Continue on THIS page*  
 No —————→ *Go to Next Page*  
 Don't Know —————→ *Go to Next Page*
- 7.1 Have you been at all breathless when the wheezing noise was present in the last 12 months?
- Yes  
 No
- 7.2 Have you had wheezing or whistling in your chest when you did not have a cold in the last 12 months?
- Yes  
 No
- 7.3 Have you had wheezing or whistling in your chest while you were at home (indoors or outdoors) in the last 12 months?
- Yes  
 No
- 7.4 Have you had wheezing or whistling in your chest while you were at work in the last 12 months?
- Yes  
 No
- 7.5 While you were away from work in the last 12 months, was your wheezing or whistling: worse, better or unchanged?
- Worse  
 Better  
 Unchanged
- 7.6 After returning to your work in the last 12 months, was your wheezing or whistling: worse, better or unchanged?
- Worse  
 Better  
 Unchanged
- 7.7 If you were away from work for 5 or more consecutive days of absence in the last 12 months, was your wheezing or whistling: worse, better or unchanged?
- Worse  
 Better  
 Unchanged  
 Not applicable
- 7.8 When you returned to your work after 5 or more consecutive days of absence in the last 12 months, was your wheezing or whistling: worse, better or unchanged?
- Worse  
 Better  
 Unchanged  
 Not applicable

8. Have you had an attack/episode of shortness of breath in the last 12 months? (Mark an X for the single best answer)

- Yes  
 No  
 Don't Know
- Go to Question 9 at the **BOTTOM** of this page

8.1 Have you had an attack/episode of shortness of breath after strenuous activity or exercise in the last 12 months?

- Yes  
 No

8.2 Have you had a daytime attack/episode of shortness of breath at rest in the last 12 months?

- Yes  
 No

8.3 Have you been awakened (at night or while sleeping) by an attack/episode of shortness of breath in the last 12 months?

- Yes  
 No

8.4 Have you had an attack/episode of shortness of breath while you were at home (indoors or outdoors) in the last 12 months?

- Yes  
 No

8.5 Have you had an attack/episode of shortness of breath while you were at work in the last 12 months?

- Yes  
 No

8.6 While you were away from work in the last 12 months, was your shortness of breath: worse, better or unchanged?

- Worse  
 Better  
 Unchanged

8.7 After returning to your work in the last 12 months, was your shortness of breath: worse, better or unchanged?

- Worse  
 Better  
 Unchanged

8.8 If you were away from work for 5 or more consecutive days of absence in the last 12 months, was your shortness of breath: worse, better or unchanged?

- Worse  
 Better  
 Unchanged  
 Not applicable

8.9 When you returned to your work after 5 or more consecutive days of absence in the last 12 months, was your shortness of breath: worse, better or unchanged?

- Worse  
 Better  
 Unchanged  
 Not applicable

9. Have you been awakened (at night or while sleeping) by an attack/episode of any of these symptoms in the last 12 months? (Indicate Yes or No for each symptom)

- | Yes                      | No                       |                 |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cough           |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest tightness |

## Participation in Activities

*Questions 10 through 13 (next page) ask you about your health and how much it impacts your participation in activities*

10. In the last 2 weeks, how much of the time did asthma or breathing problems limit any of the following activities?

	All of the time (100%)	Most of the time	Half of the time (50%)	Some of the time	None of the time (0%)
10.1 Strenuous activities (such as hurrying, exercising, running up stairs, sports)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.2 Moderate activities (such as walking, housework, gardening, shopping, climbing stairs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.3 Social activities (such as talking, playing with pets/children, visiting friends/relatives)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.4 Activities or tasks you have to do at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Have you EVER had to change your job tasks or leave a job position because of asthma or breathing problems?

- Yes  
 No

12. In the last 12 months, have you had to miss any days of work due to ANY health-related issue (whether asthma or other)?

- Yes  
 No  → Go to Question 13  
 Don't Know

12.1 *If YES*, how many days of work did you have to miss due to health-related issues? (Enter approximate number of days)

DAYS

12.1.1 Of the days indicated above, how many days did you miss due to asthma or breathing problems? (Enter approximate number of days)

DAYS

13. In the **LAST 4 WEEKS**, how much of the time did your physical health or emotional problems make it difficult for you to do the following? *(Mark an X for the single best answer for each item)*

	All of the time (100%)	Most of the time	Half of the time (50%)	Some of the time	None of the time (0%)	Does not apply to my job
13.1 Work the required number of hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.2 Get going easily at the beginning of the workday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.3 Start on your job as soon as you arrive at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.4 Do your work without stopping to take extra breaks or rests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.5 Stick to a routine or schedule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.6 Handle the workload	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.7 Work fast enough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.8 Finish work on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.9 Do your work without making mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.10 Satisfy the people who judge your work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.11 Feel a sense of accomplishment in your work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.12 Feel you have done what you are capable of doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.13 Walk or move around different work locations (for example, going to meetings)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.14 Lift, carry, or move objects at work weighing more than 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.15 Sit, stand, or stay in one position for longer than 15 minutes while working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.16 Repeat the same motions over and over again while working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.17 Bend, twist, or reach while working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.18 Use hand-held tools or equipment (for example, a phone, pen, keyboard, computer mouse, drill, hairdryer or sander)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.19 Keep your mind on your work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.20 Think clearly when working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.21 Do work carefully	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.22 Concentrate on your work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.23 Work without losing your train of thought	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.24 Easily read or use your eyes when working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.25 Speak with people in person, in meetings or on the phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.26 Control your temper around people when working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.27 Help other people to get work done	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Allergies

*Questions 14 through 17 ask you about allergies and family medical history*

- 14. Have you ever had any of the following conditions? (Indicate Yes or No for each condition)**
- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
- 15. When you are near animals (cats/dogs/horses), feathers (pillows/quilts/duvet), or in a dusty part of the house, do you ever: (Indicate Yes or No for each symptom)**
- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
- 16. When you are near trees, grass, or flowers, or when there is a lot of pollen around, do you ever:**
- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> |
- 17. Have any of your parents, siblings or children had any of the following conditions? (Indicate Yes, No or Don't Know for each condition)**
- |  | Yes                      | No                       | Don't Know               |
|--|--------------------------|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## House or Apartment

*Questions 18 and 19 ask you to describe the house or apartment you currently live in*

- 18. In your house or apartment, are there visible areas of mold, mildew or water damage?**
- |  |                              |                            |
|--|------------------------------|----------------------------|
|  | <input type="checkbox"/> Yes |                            |
|  | <input type="checkbox"/> No  | → <b>Go to Question 19</b> |
- 18.1 If YES, how long have they been there? (Circle Days, Months or Years)**
- |       |        |
|-------|--------|
|       | Days   |
| _____ | Months |
| _____ | Years  |
- 19. In your house or apartment, are there any unusual odors?**
- |  |                              |                          |
|--|------------------------------|--------------------------|
|  | <input type="checkbox"/> Yes |                          |
|  | <input type="checkbox"/> No  | → <b>Go to Next Page</b> |
- 19.1 If YES, how long have they been there? (Circle Days, Months or Years)**
- |       |        |
|-------|--------|
|       | Days   |
| _____ | Months |
| _____ | Years  |

## Occupational History

*Questions 20 through 27 ask you about your CURRENT or MOST RECENT Job*

**20. In which month and year did you begin your current or most recent job?**

	/	
Month		Year

**21. In which month and year did you stop working at this job?**

	/		<input type="checkbox"/> Not applicable
Month		Year	

**22. How many hours per week did/do you usually work on this job, including overtime?**

	HOURS PER WEEK
--	----------------

**23. During this time, were/are you a student in this job? (Mark an X for the single best answer)**

Yes  
 No

**24. Which of the following best describes the hours you usually work in this job? (Mark an X for the single best answer)**

- |  |   |
|--|---|
| <input type="checkbox"/> Regular daytime shift | <input type="checkbox"/> Rotating shift |
| <input type="checkbox"/> Regular evening shift | <input type="checkbox"/> Other          |
| <input type="checkbox"/> Regular night shift   |   |

**25. While working at this job, indicate how often, on average, you handled or were exposed to any of the following products? (Select the single best answer for each item)**

	At least once a month	At least once a week	Never
Disinfectants/sterilants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex gloves/products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aerosolized medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adhesives/adhesive removers/glues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gases/vapors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glutaraldehyde (Cidex®) or ortho-Phtalaldehyde (Cidex OPA®) or enzymatic cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Floor strippers/wax/buffers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlorinated bleach/bleach (hypochlorite)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quaternary Ammonium Compounds (QACs/Quats)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**26. What kind of business or industry is/was this? (Mark an X for the single best answer)**

- |   |  |
|---|--|
| <input type="checkbox"/> Hospital (Urban)             | <input type="checkbox"/> Public School   |
| <input type="checkbox"/> Hospital (Rural)             | <input type="checkbox"/> Nursing Home    |
| <input type="checkbox"/> Private Practice             | <input type="checkbox"/> Research        |
| <input type="checkbox"/> Outpatient Clinic (Surgical) | <input type="checkbox"/> Medical Sales   |
| <input type="checkbox"/> Outpatient Clinic (Other)    | <input type="checkbox"/> Academia        |
| <input type="checkbox"/> Health Department (Urban)    | <input type="checkbox"/> Home Health     |
| <input type="checkbox"/> Health Department (Rural)    | <input type="checkbox"/> Dental Office   |
| <input type="checkbox"/> Health Insurance Agency      | <input type="checkbox"/> Other (Specify) |

**27. What is/was your job title? (Mark an X for the single best answer)**

- |  |   |
|--|---|
| <input type="checkbox"/> LVN-General/Specialty | <input type="checkbox"/> CNA-Administrative     |
| <input type="checkbox"/> LVN-Operating Room    | <input type="checkbox"/> CNA-Other              |
| <input type="checkbox"/> LVN-Administrative    | <input type="checkbox"/> Nurse Practitioner     |
| <input type="checkbox"/> LVN-Other             | <input type="checkbox"/> Physician              |
| <input type="checkbox"/> RN-General/Specialty  | <input type="checkbox"/> Respiratory Therapist  |
| <input type="checkbox"/> RN-Operating Room     | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> RN-Administrative     | <input type="checkbox"/> Physical Therapist     |
| <input type="checkbox"/> RN-Other              | <input type="checkbox"/> Physician's Assistant  |
| <input type="checkbox"/> CNA-General/Specialty | <input type="checkbox"/> Other (Specify)        |
| <input type="checkbox"/> CNA-Operating Room    | ↓   |

**27.1 IF WORKING AS GENERAL/SPECIALTY RN/LVN/CNA, which of these best fits your workplace?**

- Floor-ICU  
 Floor-Non Surgical  
 Floor-Surgical  
 Endoscopy/Bronchoscopy  
 Special Infusion/Injection  
 Other (Specify)



## Occupational History

*Questions 28 through 35 ask you about your LONGEST HELD Job*

**28. Is your current or most recent job also your longest job?**

- Yes → *Go to Next Page*  
 No

**29. In which month and year did you begin your longest held job?**

/	
Month	Year

**30. In which month and year did you stop working at this job?**

/	
Month	Year

**31. How many hours per week did you usually work on this job, including overtime?**

 HOURS PER WEEK

**32. During this time, were you a student in this job? (Mark an X for the single best answer)**

- Yes  
 No

**33. While working at this job, indicate how often, on average, you handled or were exposed to any of the following products? (Select the single best answer for each item)**

	At least once a month	At least once a week	Never
Disinfectants/sterilants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex gloves/products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aerosolized medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adhesives/adhesive removers/ glues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gases/vapors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glutaraldehyde (Cidex®) or ortho- Phtalaldehyde (Cidex OPA®) or enzymatic cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Floor strippers/wax/buffers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlorinated bleach/bleach (hypochlorite)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quaternary Ammonium Compounds (QACs/Quats)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**34. What kind of business or industry was this? (Mark an X for the single best answer)**

- |   |  |
|---|--|
| <input type="checkbox"/> Hospital (Urban)             | <input type="checkbox"/> Public School   |
| <input type="checkbox"/> Hospital (Rural)             | <input type="checkbox"/> Nursing Home    |
| <input type="checkbox"/> Private Practice             | <input type="checkbox"/> Research        |
| <input type="checkbox"/> Outpatient Clinic (Surgical) | <input type="checkbox"/> Medical Sales   |
| <input type="checkbox"/> Outpatient Clinic (Other)    | <input type="checkbox"/> Academia        |
| <input type="checkbox"/> Health Department (Urban)    | <input type="checkbox"/> Home Health     |
| <input type="checkbox"/> Health Department (Rural)    | <input type="checkbox"/> Dental Office   |
| <input type="checkbox"/> Health Insurance Agency      | <input type="checkbox"/> Other (Specify) |



**35. What was your job title? (Mark an X for the single best answer)**

- |  |   |
|--|---|
| <input type="checkbox"/> LVN-General/Specialty | <input type="checkbox"/> CNA-Administrative     |
| <input type="checkbox"/> LVN-Operating Room    | <input type="checkbox"/> CNA-Other              |
| <input type="checkbox"/> LVN-Administrative    | <input type="checkbox"/> Nurse Practitioner     |
| <input type="checkbox"/> LVN-Other             | <input type="checkbox"/> Physician              |
| <input type="checkbox"/> RN-General/Specialty  | <input type="checkbox"/> Respiratory Therapist  |
| <input type="checkbox"/> RN-Operating Room     | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> RN-Administrative     | <input type="checkbox"/> Physical Therapist     |
| <input type="checkbox"/> RN-Other              | <input type="checkbox"/> Physician's Assistant  |
| <input type="checkbox"/> CNA-General/Specialty | <input type="checkbox"/> Other (Specify)        |
| <input type="checkbox"/> CNA-Operating Room    | ↓   |

**35.1 IF WORKING AS GENERAL/SPECIALTY RN/LVN/CNA, which of these best fits your workplace?**

- Floor-ICU  
 Floor-Non Surgical  
 Floor-Surgical  
 Endoscopy/Bronchoscopy  
 Special Infusion/Injection  
 Other (Specify)



## Jobs (continued)

*Questions 36 asks you about jobs that you have EVER had*

36. Think about **all of the jobs** you have ever had. To the best of your knowledge have you ever used or been in contact with any of the following materials at least **once a week**? (*Indicate Yes or No for each one*)

Yes No

- Bleach
- Cleaners/abrasives for room/counter top
- Cleaners/abrasives for restroom/toilets
- Detergents
- Disinfectants
- Floor strippers/wax/buffers
- Sprays

Yes No

- Ammonia
- Pesticide
- Paints (acrylics, stains/varnishes)
- Tobacco smoke (including passive)
- Solvents (toluene, xylene, benzene, hexane, mineral spirits, paint thinners)
- Toner for copiers or printers
- Talc

Yes No

- Glutaraldehyde (Cidex®)
- ortho-Phtalaldehyde (Cidex OPA®)
- Enzymatic cleaners
- Adhesives or glues
- Quaternary Ammonium Compounds (QACs/Quats)

Yes No

- Anesthetics
- Antibiotics
- Antiseptics
- Bronchodilators
- Iodine (Povidone iodine, Betadine®)
- Nebulized drugs (pentamidine or ribavirin)

Yes No

- Acetaldehyde
- Alkalis
- Ethylene oxide
- Formalin/formaldehyde
- Nitric oxide

## Accidental Chemical/Powder Spill or Gas Release

*Questions 37 asks you about exposure to an accidental chemical/powder spill or gas release*

37. Were you ever involved in an accidental chemical spill or gas release?

- Yes
- No  → *Go to Next Page*
- Don't Know

37.1 Did this accidental chemical spill or gas release occur at work? (*Mark an X for the single best answer*)

- Yes
- No

37.2 In the first 24 hours following this accident, did you experience any of the following symptoms? (*Indicate Yes or No for each symptom*)

Yes No

- Wheezing
- Shortness of breath
- Cough
- Chest tightness

37.3 Did you have to receive medical attention because of this accident? (*Mark an X for the single best answer*)

- Yes
- No
- Don't Know/Don't Remember

37.4 When did this accident occur?

/

Month                      Year

## Demographics

38. What is your date of birth?

	/		/	
Month		Day		Year

39. What is your gender?

- Male  
 Female

40. Do you consider yourself Spanish/Hispanic/Latino? (Mark an X for the single best answer)

- No, not Spanish/Hispanic/Latino  
 Yes, Mexican, Mexican American, Chicano  
 Yes, Puerto Rican  
 Yes, Cuban  
 Yes, other Spanish/Hispanic/Latino (specify):

41. What is your race? (Mark an X for the single best answer)

- White  
 Black  
 Asian, Asian-American or Pacific Islander  
 American Indian or Alaska Native  
 Another race (specify):

42. What is your standing height?

	/	
Feet		Inches

43. How much do you weigh?

Pounds

44. What is the highest grade or level of education that you have completed? (Mark an X for the single best answer)

- High school graduate or GED  
 Some college or vocational/technical school  
 4-year college graduate (Bachelor's Degree)  
 Graduate/Medical/Law school

45. How many years have you worked as a health care professional? (Include years as a healthcare student)

 YEARS

46. Have you smoked at least 100 cigarettes during your life?

- Yes  
 No

47. Do you smoke cigarettes now?

- Yes  
 No → Go to Question 48

47.1 If YES, how many cigarettes do you smoke per day?

- Less than 1/2 pack each day  
 1/2 to 1 pack a day  
 > 1 to 2 packs a day  
 > 2 to 3 packs a day  
 More than 3 packs a day

48. Do you use e-cigarettes?  Yes  
 No

49. Would you say your health in general is...?

- Excellent  
 Very good  
 Good  
 Fair  
 Poor

***Thank you for completing this survey.***  
 Please return this survey in the envelope provided to:  
 PO Box 20186  
 Houston, Texas 77225-9901