The Role of Environmental Contaminants in ALS

EXPOSURE HISTORY SURVEY/QUESTIONNAIRE

For office use only

Unique I.D. ____________________

Date (Administered) ______/_____/_______

Date (Received) ______/_____/_______

Received by (Name) ____________________

BEFORE YOU BEGIN:

This survey is designed for completion by individuals with ALS and those without the disease that are participating in the survey portion of the research study ‘Epidemiologic Risk Factors and the Genetics of ALS’.

Instruction to complete the survey:

If a patient with ALS is unable to complete this survey, then his/her caregiver or next of kin can complete it, but remember that all questions pertain to the patient.

For questions with multiple answers, please put a check mark (X) in the appropriate box. You can choose more than one choice if it applies.

Some portions of the questionnaire may be technical, and others will ask you to remember things from many years ago. It is important to make a good effort to complete the entire survey as accurately as you can.

If at any time you feel that you need help with any portion of this questionnaire, please feel free to contact the study coordinator, Susan Nalepa by telephone at 734 615 9891 or by email at sumsn@umich.edu.

If there are portions of this questionnaire that you would rather do by telephone, then please write T in the margins of that section before you return the survey and the project coordinator will contact you.

There is also a section for additional comments and/or questions.

Finally, we request that you complete the survey questionnaire and mail it to us in the stamped and addressed envelope provided within 2 weeks.
I am participating as:
AN ALS PATIENT □  AN INDIVIDUAL WITHOUT ALS □

PERSONAL INFORMATION

1. Please provide your (participant) information below:
   1a Last ______________________________________________________________
   1b First _____________________________________________________________
   1c M.I.__________
   1d Maiden__________________________________________________________
   1e Sex: □ 0 Male   □ 1 Female

2a. Do you consider yourself to be Hispanic or Latino?  □ 1 Yes  □ 2 No

2b. What race or races do you consider yourself to be? (You can select more than one.)
   □ 1 White            □ 9 Asian Indian
   □ 2 Black/African American □ 10 Chinese
   □ 3 Indian (American)  □ 11 Filipino
   □ 4 Alaskan Native     □ 12 Japanese
   □ 5 Native Hawaiian    □ 13 Korean
   □ 6 Guamanian          □ 14 Vietnamese
   □ 7 Samoan             □ 15 Other Asian
   □ 8 Other Pacific Islander □ 16 Some other race

3a. What is the HIGHEST level of school completed or the highest degree received?:
   □ 1 Never attended/kindergarten only □ 3 High school graduate
   □ 2 1st-8th grade                   □ 9 Some college, no degree
   □ 3 9th grade                      □ 10 Associate degree
   □ 4 10th grade                     □ 11 Bachelor’s degree
   □ 5 11th grade                     □ 12 Master’s degree, Professional school degree,
   □ 6 12th grade, no diploma         Doctoral degree
   □ 7 GED or equivalent

3b. Are you now married, widowed, divorced, separated, never married, or living with a partner?
   □ 1 Married                       □ 4 Separated
   □ 2 Widowed                       □ 5 Never married
   □ 3 Divorced                      □ 6 Living with partner

4. In what town, state and country were you born?  
   4a Town__________________________________________________________
   4b State_________________________________________________________
   4c Country_______________________________________________________

5. When were you born?  MM/DD/YYYY _______/_______/______
6. What is your current address and telephone number?
   6a Street ________________________________________________________________
   6b City _________________________________________________________________
   6c State _______________ 6d Zip Code ___________
   6e County ____________________________________________
   6f Telephone number ________________________________

7. If we need to telephone you to ask you about your responses on this survey, are there some particularly good days and times to call or not to call?
   7a □ Most days and times are OK – Skip to next question

   7b Best to call these days
      □ 1 Most days are OK  □ 5 Thursday
      □ 2 Monday  □ 6 Friday
      □ 3 Tuesday  □ 7 Saturday
      □ 4 Wednesday  □ 8 Sunday

   7c Best to call at these times
      □ 1 Most times are OK
      □ 2 Morning
      □ 3 Afternoon
      □ 4 Evening

8. Is this form being filled out by someone other than the participant listed above in Question # 1?
   □ 0 No  □ 1 Yes

   If yes, please provide the following:
      i) Name of the person filling out the form: _________________________________
      ii) Relationship to the participant:
          □ 1 Related
          □ 2 Non-related
          □ 3 Other – Describe __________________________
      iii) The person is helping the participant by
          □ 1 Providing answers in place of the participant (a proxy respondent)
          □ 2 Communicating with participant to fill out the form
RESIDENCE HISTORY

Chronologically list your (individual with ALS or healthy individual) past and present residences, starting with your most current residence. Include addresses where you lived for at least three (3) months. Start with the current or most recent first. If you can’t remember exact addresses, skip that and provide the city, state/province and country. It is important to recall homes for the past 20 years and the home that you lived in when you were born.

If you cannot remember the exact date when you moved in or moved out, then for move-in date try to remember how old you were when you started living there and put the approximate date. And for move out date try to remember how old you were when you moved out of there or how long you lived there and put the approximate date.

<table>
<thead>
<tr>
<th>No.</th>
<th>Move in MM/YY 7a</th>
<th>Moved out MM/YY 7b</th>
<th>Address 7c</th>
<th>City 7d</th>
<th>State or Province w/ZIP 7e</th>
<th>Country 7f</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Use the additional sheet provided if necessary
<table>
<thead>
<tr>
<th>No.</th>
<th>Move in MM/YY 7a</th>
<th>Moved out MM/YY 7b</th>
<th>Address 7c</th>
<th>City 7d</th>
<th>State or province w/ZIP 7e</th>
<th>Country 7f</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HOUSE # 1

THIS IS FOR THE HOUSE THAT YOU LIVE IN NOW.
(PART A)
HOUSING

Part A of this form is to be used for the current/most recent home
Part B is to be used for the home that you were born in as well as two other homes that you lived in the longest (3 copies have been provided for your convenience).

*If an ALS patient, please answer questions as things were before the diagnosis of ALS.*

**Part A: This part for your current home**

*The following should be filled out for your current home. Sometimes it is helpful to walk through some parts of your home to obtain this information.*

**General Characteristics:**

1. Type of building:  
   - □₁ Single family, detached
   - □₂ Duplex
   - □₃ Multi-family/APartment
   - □₄ Mobile home or trailer
   - □₅ Other – Describe → 1a __________________________
   - □₆ Don’t know

2. About when was this house/structure originally built?  Year: _________________

3. How long have you lived at this address?  _______ years

4. Building is made mostly of:  
   - □₁ Wood
   - □₂ Brick
   - □₃ Other – Describe → 4a __________________________

5. Floor coverings in the home:  
   - □₁ Hard surface (e.g., wood, linoleum, etc.)
   - □₂ Carpeting
   - □₃ Both

6. Is there a basement or crawlspace:  
   - □₀ No
   - □₁ Yes

7. Outdoor storage:  
   - □₀ None
   - □₁ Storage shed
   - □₂ Overhang, awning or other unenclosed area
   - □₃ Other – Describe → 7a __________________________

**Potential Emission Sources in or near the Home**

8. Where are cars usually parked?  
   - □₁ Outside garage
   - □₂ Inside garage
   - □₃ Both
   - □₄ Other – Describe → 8a __________________________
9. Type of garage:  
☐ 0 None  ☐ 3 Carport  
☐ 1 Attached  ☐ 4 Other –  
☐ 2 Not-attached  
Describe → 9a ________________________

If there is no garage, skip to question 13.

10. The garage is:  
☐ 1 Clean  
☐ 2 Moderately cluttered  
☐ 3 Very cluttered  
☐ 4 Other – Describe → 10a ________________________

11. Check all the chemicals and other items that are or that have been stored in the garage.
☐ 1 Ammonia (Bleach, Clorox etc)  
☐ 2 Pesticides (Raid, Orange glow etc)  
☐ 3 Solvents (benzene, acetone, turpentine, methanol)  
☐ 4 Gasoline and/or kerosene in containers  
☐ 5 Lawn mower(s), chain saw(s), etc.  
☐ 6 Lawn care products (fertilizer, pesticides, tree sprays)  
☐ 7 Paint  
☐ 8 Woodworking supplies (e.g., varnish, turpentine)  
☐ 9 Other – Describe → 11a ________________________

12. For those chemicals in the garage, they are stored:  
☐ 1 Enclosed (i.e., in cabinet or other enclosure)  
☐ 2 Open (e.g., on a shelf, floor, etc.)  
☐ 3 Both  
☐ 4 Other – Describe → 12a ________________________

13. Check all the chemicals you may have stored in the house.
☐ 1 Ammonia (Bleach, Clorox etc)  
☐ 2 Pesticides (Raid, Orange Glow etc)  
☐ 3 Solvents (benzene, acetone, turpentine, methanol)  
☐ 4 Gasoline and/or kerosene in containers  
☐ 5 Lawn mower(s), chain saw(s), etc.  
☐ 6 Lawn care products (fertilizer, pesticides, tree sprays)  
☐ 7 Paint  
☐ 8 Woodworking supplies  
☐ 9 Other – Describe → 13a ________________________

14. Check all of the following that you have in your home:
☐ 1 Air purifier (filter)  
☐ 2 Air conditioner  
☐ 3 Humidifier  
☐ 4 Central heating - gas  
☐ 5 Central heating – oil  
☐ 6 Electric Heating (baseboard)  
☐ 7 Central heating – other  
☐ 8 Fireplace/wood stove

15. Is one or more space heater(s) used to heat this home? We are only interested in heaters that are not vented to the outside?
☐ 0 No  ☐ 1 Yes  ☐ 2 Don't know

16. What is the fuel for the room or space heater?
☐ 1 Electricity  
☐ 2 Kerosene  
☐ 3 Propane  
☐ 4 Other – Describe 16a

______________________________
17. Is one or more wood stoves or fireplaces used?  □ 0 No  □ 1 Yes  □ 2 Don’t know

18. Is a stove or oven used for cooking at this home?
   □ 0 None  □ 3 Wood stove
   □ 1 Gas stove  □ 4 Microwave
   □ 2 Electric stove

19. Is there an exhaust fan near this stove that send fumes outside the house?
   □ 0 No  □ 1 Yes  □ 2 Don’t know

20. When the stove or oven is being used, how often is this exhaust fan used?
   □ 0 Never  □ 3 Always
   □ 1 Rarely  □ 4 Don’t know
   □ 2 Sometimes

21. Did you ever use this stove or oven to heat this home?
   □ 0 No  □ 1 Yes  □ 2 Don’t know

22. Is there standing water next to the home?
   □ 0 No  □ 1 Yes  □ 2 Don’t know

23. Is there evidence of water leaks indoors? (Check all that apply.)
   □ 1 Ceiling  □ 3 Floor
   □ 2 Walls  □ 5 Other
   □ 4 Other – Describe → 24a

24. How close is the home to a major road (i.e., paved roads with considerable traffic)
   □ 1 Immediately adjacent (closer than 1 block)  □ 4 Can’t tell
   □ 2 1 to 4 blocks (less than ¼ mile)  □ 5 Other – Describe → 24a
   □ 3 Greater than 4 blocks (or ¼ mile)

25. Do you live next to or near any of the following?
   □ 1 Construction site  □ 8 Recycling/Reclamation facility
   □ 2 Industrial operation (e.g., factory, etc.)  □ 9 Gas station
   □ 3 Farm  □ 10 Trucking/warehousing
   □ 4 Golf course  □ 11 Other – Describe
   □ 5 Sewage treatment plant  → 25a _______________________
   □ 6 Refinery  □ 12 Don’t know/can’t tell
   □ 7 Landfill

26. Is there clutter or excessive storage of any material or chemicals next to your home?
   □ 0 No  □ 1 Yes  □ 2 Don’t know

26a If yes, check all that describe the clutter
   □ 1 Accumulation of leaves, mulch, shrubs etc.
   □ 2 Dumpster overflowing with perishable household trash (arising from food preparation) paper, plastic bottle (milk, juice) or cans (soda, preserved food) etc
   □ 3 Empty or filled containers (with or without spills) of household products (e.g. oven cleaner, toilet bowl cleaner, tub and tile cleaner drain cleaner, floor care products etc.)
   □ 4 Empty or filled containers of car care products (e.g. brake fluid, car wax, oil etc) or wood care products (glue, paint, paint stripper, primer wood preservatives etc.)
   □ 5 Garden care products e.g. fertilizer, fungicide, insecticide, weed killer, herbicide etc.
   □ 6 Other – Please explain 26a _____________________________
27. Have you ever changed your residence because of a health problem?
☐ 0  No (SKIP TO 28)  ☐ 1  Yes

27a. If yes, when did you change residence __________________ (year)

27b. Who suffered?  ☐ 1  You
☐ 2  Your spouse /child
☐ 3  Other – Explain __________________________

27c. Check all of the following that describe the nature of the health problem.
☐ 1  Continued sneezing, runny or stuffy nose, itchy/watery eyes (due to allergy to dust, carpet)
☐ 2  Sudden development shortness of breath, tightness of chest (like asthma).
☐ 3  Rash, redness and itching of skin (like hives)
☐ 4  Recurring cold, chronic cough, breathing difficulty, skin rash or diarrhea (due to mold)
☐ 5  Fever, chills, pain in the chest, cough (like in pneumonia).
☐ 6  Dizziness, headache, tiredness, nose /throat irritation.
☐ 7  Other – Explain 27c1

Home Repairs and Renovation

The next group of questions is about work that has ever been done while you have lived in this home.

28. Have you weatherized your home?  ☐ 0  No  ☐ 1  Yes  ☐ 2  Don't know

28a. If yes, dates of weatherization ________________, _______________, ________________

28b. What was done to weatherize the home? Check all that apply
☐ 1  Improved insulation of the ceiling, floor, ducts and pipes
☐ 2  Plastic covers on windows or new windows
☐ 3  Hot water tank wrap and low-flow showerheads.
☐ 4  Caulking or other sealing to prevent drafts and cold/hot air leaks
☐ 5  Other – 28b1___________________

29. Have you even had any areas inside your home painted, including walls, floors, trim or ceilings?
☐ 0  No  ☐ 1  Yes  ☐ 2  Don’t know

30. When this area was painted, did someone sand or scrape off any of the old paint?
☐ 1  sand  ☐ 2  scrape  ☐ 3  Don’t know

31. Are there any rooms in your home where you can see paint that is peeling, flaking or chipping off
the walls ceiling, doors or windows?
☐ 0  No  ☐ 1  Yes  ☐ 2  Don’t know

32. In any of these rooms, can you see at least one total area of peeling, flaking or chipping paint that
is larger than one page of a regular newspaper?
☐ 0  No  ☐ 1  Yes  ☐ 2  Don’t know

33. How many rooms have this much peeling, flaking or chipping paint? _______ (number)

34. Can you see paint that is peeling, flaking or chipping on any outside area of your home?
☐ 0  No  ☐ 1  Yes  ☐ 2  Don’t know
35. Can you see any total area of peeling, flaking or chipping paint on any outside area of your home that is larger than a regular door?
   - 0 No
   - 1 Yes
   - 2 Don’t know

36. Can you see any area of the roof of your home where roofing material (e.g., shingles) is broken or missing from an area that is larger than a sheet of newspaper?
   - 0 No
   - 1 Yes
   - 2 Don’t know

*The next questions are about work that has been done in your home.*

37. Have you or anyone else done any of the following? Check all that apply.
   - 1 Painted walls/trim/other
   - 2 Scraped off old paint
   - 3 Replaced a window in your home?
   - 4 Replaced a kitchen cabinet?
   - 5 Removed a wall in your home?
   - 6 Repaired/replaced any part of the roof?

*If none of the activities are checked, skip to question no. 39*

38a. Who did the work?  
   - 1 Yourself
   - 2 Other family member living in your home
   - 3 A professional
   - 4 Other – Describe 38b ________

38b. Considering all work that has been done, about how long did it take to finish the work? ____ days

38c. In which years was work performed? ________, ________, ________, ________

**Pets and Pesticide Use**

*If no pets live or have previously lived with you in the house, skip to question no 47.*

39. What types of pets live or have lived here?
   - 0 None
   - 1 Dog(s)
   - 2 Cat(s)
   - 3 Bird(s)
   - 4 Other – Describe 39a

40. Did you notice any abnormal change in the health or behavior of family pets?
   - 0 No
   - 1 Yes

41. Check all of the following that you use on your pet(s)
   - 1 Sprays for fleas, mites, etc.
   - 2 Collars for fleas, mites, etc.
   - 3 Powders for fleas, mites, etc.
   - 4 Shampoo for fleas, mites, etc.

42. Have you had trouble with any of the following types of pests in your house? Check any that apply.
   - 0 None
   - 1 Mice
   - 2 Cockroaches
   - 3 Rats
   - 4 Fleas
   - 5 Ants
   - 6 Termites
   - 7 Other – Describe 42a
43. Did you or someone else treat the home for pests?
   □ 0  No     □ 1  Yes     □ 2  Don’t know

   *If no, skip to question no 47.*

44. Which of the following areas of your home were treated with these chemical products?
   (For example, products used to control fleas, roaches, ants, termites or other insects?)
   □ 0  None     □ 6  Basement
   □ 1  Living room or family room     □ 7  Other (den, playroom, rec. room).
   □ 2  Dining Room     □ 8  Outside – to foundation or building
   □ 3  Kitchen     □ 9  Entire house
   □ 4  Bathroom(s)     □10 Don’t know
   □ 5  Bedroom(s)

45. We would like to know who applied these chemical products and the number of times they applied them. When these chemical products were used to treat your home, how many times per year were they used?
   a. You applied these products?        ____ /year
   b. Some living in your home other than you applied these products?   ____ /year
   c. A professional exterminator applied these products?    ____ /year
   d. Someone other than a professional or household member applied these products
      (For example, a neighbor or relative living outside your home)?   ____ /year

46. Check all of the following treatments that you have used:
   □ 1  Traps     □ 4  Gel Application
   □ 2  Residual spray     □ 5  Fumigation
   □ 3  Powder application     □ 6  Other – Describe 46a__________

47. Does the outdoor area around this home have a private yard or garden?
   □ 0  No     □ 1  Yes     □ 2  Don’t know

   *If no, skip to question no 52.*

48. Did you have any of the following at this house?
   □ 1  Vegetable garden (tomato, corn, etc.)     □ 4  Fruit trees
   □ 2  Flower/rose garden     □ 5  Herb garden
   □ 3  Yard

49. Did you or others treat your lawn, yard or garden with chemicals to kill insects, weeds or plant diseases?
   □ 0  No     □ 1  Yes     □ 2  Don’t know

   *If no, skip to question no 52.*

50. We would like to know who applied these chemical products and the number of times they applied them. When these chemical products were used to treat the area around your home (e.g. lawn, yard garden), how many times per year were they used?
   a. You applied these products?        ____ /year
   b. Some living in your home other than you applied these products?   ____ /year
   c. A professional exterminator applied these products?    ____ /year
   d. Someone other than a professional or household member applied these products
      (For example, a neighbor or relative living outside your home)?   ____ /year
51. Which of the following treatment(s) you have used:
   □ 1  Fertilizer  □ 5  Weed killer
   □ 2  Herbicide /weed killer  □ 6  Animal or rodent repellents
   □ 3  Fungicide (prevents black spots)  □ 7  Chemicals to control slug, snails
   □ 4  Insecticide  □ 8  Other.._________________________

Drinking Water and Tap Water

52. In your home, what kind of water do you normally use for drinking and cooking?
   □ 0  Tap water  □ 1  Bottled water  □ 2  Both

53. What is the source of your home tap water?
   □ 1  Private well
   □ 2  City water supply
   □ 3  Spring
   □ 4  Don’t know

54. Does your home drinking or cooking water have a water softening or conditioning system? This may include systems at the tap or faucet, under the sink, or a system for the entire home?
   □ 0  No  □ 1  Yes  □ 2  Don’t know

54a. If yes, then indicate water treatment system(s) that is (are) used.
   □ 1  Faucet mounted or pitcher filter
   □ 2  Water softener
   □ 3  Aerator
   □ 4  Reverse osmosis
   □ 5  Other – Describe → 54a1_____________
   □ 6  Don’t know/can’t tell
HOUSE # 2

THIS IS FOR THE HOUSE THAT YOU LIVED IN WHEN YOU WERE BORN.
(PART B)
PART B: This part is to be used for the **home that you were born in** (House #2) as well as **two other homes that you lived in the longest**. (House #3 and House #4)

We want you to provide information on your previous home. Refer back to page 4 to identify which home this is.

The next three pages of the survey refer to house number _______

**General Characteristics:**

1. What type of building was your previous home?  
   - □ 1 Single family, detached  
   - □ 2 Duplex  
   - □ 3 Multi-family/Apartment  
   - □ 4 Mobile home or trailer  
   - □ 5 Other – Describe → 1a__________  
   - □ 6 Don’t know

2. About when was this house/structure originally built?  Year: _______________

3. How long have you lived at this address?  _______ years

4. Floor coverings in the home:  
   - □ 1 Hard surface (e.g., wood, linoleum, etc.)  
   - □ 2 Carpeting  
   - □ 3 Both

5. Is there a basement or crawlspace:  
   - □ 0 No  
   - □ 1 Yes

**Potential Emission Sources in or near the Home**

6. Where were the cars usually parked?  
   - □ 1 Outside garage  
   - □ 2 Inside garage  
   - □ 3 Both  
   - □ 4 Other – Describe → 6a__________

7. Type of garage of that home?  
   - □ 0 None – **Go to question 9**  
   - □ 1 Attached  
   - □ 2 Not-attached  
   - □ 3 Carport  
   - □ 4 Other – Describe → 7a__________

8. Check those chemicals and other items that were stored in the garage.  
   - □ 1 Ammonia (e.g., bleach, Clorox etc)  
   - □ 2 Pesticides (e.g., Raid, Orange Glow etc)  
   - □ 3 Solvents (benzene, acetone, turpentine, methanol)  
   - □ 4 Gasoline and/or kerosene in containers  
   - □ 5 Lawn mower(s), chain saw(s), etc.  
   - □ 6 Lawn care products (fertilizer, pesticides, tree sprays)  
   - □ 7 Paint  
   - □ 8 Woodworking supplies  
   - □ 9 Other – Describe → 8a

   → 8a__________________
9. Check all chemicals that you may have had stored in that house.
   □ 1 Ammonia (bleach, Clorox)  □ 7 Paint
   □ 2 Pesticides (e.g., Raid)  □ 8 Woodworking supplies (e.g., varnish, turpentine)
   □ 3 Solvents (e.g., benzene, acetone, turpentine, methanol)  □ 9 Other – Describe → 9a
   □ 4 Gasoline and/or kerosene in containers
   □ 5 Lawn mower(s), chain saw(s), etc.
   □ 6 Lawn care products (fertilizer, pesticides, tree sprays)

10. Check all of the following you had in that home?
    □ 1 Air purifier (filter)  □ 5 Central heating – oil
    □ 2 Air conditioner  □ 6 Electric Heating (baseboard)
    □ 3 Humidifier  □ 7 Central heating – other
    □ 4 Central heating – gas  □ 8 Fireplace/wood stove

11. Was one or more wood stoves or fireplaces used?
    □ 0 No  □ 1 Yes  □ 2 Don’t know

12. Was a stove or oven used for cooking at that home?
    □ 0 None  □ 3 Wood stove
    □ 1 Gas stove  □ 4 Microwave
    □ 2 Electric stove

13. Evidence of water leaks indoors (check all that apply) that was present at that house:
    □ 1 Ceiling  □ 3 Floor
    □ 2 Walls  □ 4 Other – Describe 13a___________

14. Proximity of that home to major road (i.e., paved road with considerable traffic):
    □ 1 Immediately adjacent (closer than 1 block)
    □ 2 1 to 4 blocks (less than ¼ mile)
    □ 3 Greater than 4 blocks (or ¼ mile)
    □ 4 Can’t tell
    □ 5 Other – Describe → 14a__________________

15. Did you live next to or near any of the following listed below:
    □ 1 Construction site  □ 8 Recycling/Reclamation facility
    □ 2 Industrial operation (e.g., factory, etc.)  □ 9 Gas station
    □ 3 Farm  □ 10 Trucking/warehousing
    □ 4 Golf course  □ 11 Other – Describe → 15a1__________________
    □ 5 Sewage treatment plant
    □ 6 Refinery  □ 12 Don’t know/can’t tell
    □ 7 Landfill  □ 0 None

16. Was there clutter or excessive storage of any material or chemicals next to that home?
    □ 0 No  □ 1 Yes  □ 2 Don’t know
16a  If **yes**, check all that describe the clutter

- ☐ 1  Accumulation of leaves, mulch, shrubs etc.
- ☐ 2  Dumpster overflowing with perishable household trash (arising from food preparation) paper, plastic bottle (milk, juice) or cans (soda, preserved food) etc
- ☐ 3  Empty or filled containers (with or without spills) of household products (e.g. oven cleaner, toilet bowl cleaner, tub and tile cleaner drain cleaner, floor care products etc.)
- ☐ 4  Empty or filled containers of car care products (e.g. brake fluid, car wax, oil etc) or wood care products (glue, paint, paint stripper, primer wood preservatives etc.)
- ☐ 5  Garden care products e.g. fertilizer, fungicide, insecticide, weed killer, herbicide etc.
- ☐ 6  Other – Please explain 16a___________________________________________

**Pets**

17. What types of pets live or have lived here?

- ☐ 0  None
- ☐ 1  Dog(s)
- ☐ 2  Cat(s)
- ☐ 3  Bird(s)
- ☐ 4  Other – Describe → 17a______________

**Drinking Water and Tap Water**

18. What was the source of your drinking and cooking water?

- ☐ 1  private well
- ☐ 2  city water supply
- ☐ 3  spring
- ☐ 4  bottled water/grocery store
- ☐ 5  Don’t know
HOUSE # 3

THIS FOR THE HOUSE THAT YOU LIVED IN THE LONGEST BESIDES THE 2 YOU HAVE ALREADY COMPLETED.
PART B: This part is to be used for the home that you were born in (House #2) as well as two other homes that you lived in the longest. (House #3 and House #4)

We want you to provide information on your previous home. Refer back to page 4 to identify which home this is.

The next three pages of the survey refer to house number ________

General Characteristics:

We want you to provide information on your previous home. Refer back to page 4 to identify which home this is.

The next three pages of the survey refer to house number ________

General Characteristics:

1. What type of building was your previous home?  
   - □ 1 Single family, detached  
   - □ 2 Duplex  
   - □ 3 Multi-family/Apartment  
   - □ 4 Mobile home or trailer  
   - □ 5 Other – Describe → 1a ________________  
   - □ 6 Don’t know

2. About when was this house/structure originally built?  Year: _______________

3. How long have you lived at this address?  _______ years

4. Floor coverings in the home:  
   - □ 1 Hard surface (e.g., wood, linoleum, etc.)  
   - □ 2 Carpeting  
   - □ 3 Both

5. Is there a basement or crawlspace:  
   - □ 0 No  
   - □ 1 Yes

Potential Emission Sources in or near the Home

6. Where were the cars usually parked?  
   - □ 1 Outside garage  
   - □ 2 Inside garage  
   - □ 3 Both  
   - □ 4 Other – Describe → 6a ________________

7. Type of garage of that home?  
   - □ 0 None – Go to question 9  
   - □ 1 Attached  
   - □ 2 Not-attached  
   - □ 3 Carport  
   - □ 4 Other – Describe → 7a ________________
8. Check those chemicals and other items that were stored in the garage.
   - [ ] Ammonia (e.g., bleach, Clorox etc)
   - [ ] Pesticides (e.g., Raid, Orange Glow etc)
   - [ ] Solvents (benzene, acetone, turpentine, methanol)
   - [ ] Gasoline and/or kerosene in containers
   - [ ] Lawn mower(s), chain saw(s), etc.
   - [ ] Lawn care products (fertilizer, pesticides, tree sprays)
   - [ ] Paint
   - [ ] Woodworking supplies
   - [ ] Other – Describe → 8a ________________

9. Check all chemicals that you may have had stored in that house.
   - [ ] Ammonia (bleach, Clorox)
   - [ ] Pesticides (e.g., Raid)
   - [ ] Solvents (e.g., benzene, acetone, turpentine, methanol)
   - [ ] Gasoline and/or kerosene in containers
   - [ ] Lawn mower(s), chain saw(s), etc.
   - [ ] Lawn care products (fertilizer, pesticides, tree sprays)
   - [ ] Paint
   - [ ] Woodworking supplies (e.g., varnish, turpentine)
   - [ ] Other – Describe → 9a ________________

10. Check all of the following you had in that home?
    - [ ] Air purifier (filter)
    - [ ] Air conditioner
    - [ ] Humidifier
    - [ ] Central heating - gas
    - [ ] Central heating – oil
    - [ ] Electric Heating (baseboard)
    - [ ] Central heating – other
    - [ ] Fireplace/wood stove

11. Was one or more wood stoves or fireplaces used?
    - [ ] No
    - [ ] Yes
    - [ ] Don’t know

12. Was a stove or oven used for cooking at that home?
    - [ ] None
    - [ ] Gas stove
    - [ ] Electric stove
    - [ ] Wood stove
    - [ ] Microwave

13. Evidence of water leaks indoors (check all that apply) that was present at that house:
    - [ ] Ceiling
    - [ ] Walls
    - [ ] Floor
    - [ ] Other – Describe 13a ________________
14. Proximity of that home to major road (i.e., paved road with considerable traffic):
   □ 1 Immediately adjacent (closer than 1 block)
   □ 2 1 to 4 blocks (less than ¼ mile)
   □ 3 Greater than 4 blocks (or ¼ mile)
   □ 4 Can’t tell
   □ 5 Other – Describe → 14a____________________

15. Did you live next to or near any of the following listed below:
   □ 1 Construction site
   □ 2 Industrial operation (e.g., factory, etc.)
   □ 3 Farm
   □ 4 Golf course
   □ 5 Sewage treatment plant
   □ 6 Refinery
   □ 7 Landfill
   □ 8 Recycling/Reclamation facility
   □ 9 Gas station
   □ 10 Trucking/warehousing
   □ 11 Other – Describe → 15a1__________________
   □ 12 Don’t know/can’t tell
   □ 0 None

16. Was there clutter or excessive storage of any material or chemicals next to that home?
   □ 0 No  □ 1 Yes  □ 2 Don’t know

16a If yes, check all that describe the clutter
   □ 1 Accumulation of leaves, mulch, shrubs etc.
   □ 2 Dumpster overflowing with perishable household trash (arising from food preparation) paper, plastic bottle (milk, juice) or cans (soda, preserved food) etc
   □ 3 Empty or filled containers (with or without spills) of household products (e.g. oven cleaner, toilet bowl cleaner, tub and tile cleaner drain cleaner, floor care products etc.)
   □ 4 Empty or filled containers of car care products (e.g. brake fluid, car wax, oil etc) or wood care products (glue, paint, paint stripper, primer wood preservatives etc.)
   □ 5 Garden care products e.g. fertilizer, fungicide, insecticide, weed killer, herbicide etc.
   □ 6 Other – Please explain 16a___________________________________________

Pets

17. What types of pets live or have lived here?
   □ 0 None  □ 1 Dog(s)  □ 3 Bird(s)
   □ 2 Cat(s)
   □ 4 Other – Describe → 17a____________________

Drinking Water and Tap Water

18. What was the source of your drinking and cooking water?
   □ 1 private well
   □ 2 city water supply
   □ 3 spring
   □ 4 bottled water/grocery store
   □ 5 Don’t know
HOUSE #4

THIS IS FOR THE HOUSE THAT YOU LIVED IN THE NEXT LONGEST BESIDES THE 3 YOU HAVE ALREADY COMPLETED.
PART B: This part is to be used for the home that you were born in (House #2) as well as two other homes that you lived in the longest. (House #3 and House #4)

We want you to provide information on your previous home. Refer back to page 4 to identify which home this is.

The next three pages of the survey refer to house number ________

**General Characteristics:**

We want you to provide information on your previous home. Refer back to page 4 to identify which home this is.

The next three pages of the survey refer to house number ________

**General Characteristics:**

1. What type of building was your previous home?  
   - [ ] 1 Single family, detached  
   - [ ] 2 Duplex  
   - [ ] 3 Multi-family/Apartment  
   - [ ] 4 Mobile home or trailer  
   - [ ] 5 Other – Describe → 1a ________________  
   - [ ] 6 Don’t know

2. About when was this house/structure originally built?  Year: ________________

3. How long have you lived at this address?  _______ years

4. Floor coverings in the home:  
   - [ ] 1 Hard surface (e.g., wood, linoleum, etc.)  
   - [ ] 2 Carpeting  
   - [ ] 3 Both

5. Is there a basement or crawlspace:  
   - [ ] 0 No  
   - [ ] 1 Yes

**Potential Emission Sources in or near the Home**

6. Where were the cars usually parked?  
   - [ ] 1 Outside garage  
   - [ ] 2 Inside garage  
   - [ ] 3 Both  
   - [ ] 4 Other – Describe → 6a ________________

7. Type of garage of that home?  
   - [ ] 0 None – **Go to question 9**  
   - [ ] 1 Attached  
   - [ ] 2 Not-attached  
   - [ ] 3 Carport  
   - [ ] 4 Other – Describe → 7a ________________
8. Check those chemicals and other items that were stored in the garage.
   - Ammonia (e.g., bleach, Clorox etc)
   - Pesticides (e.g., Raid, Orange Glow etc)
   - Solvents (benzene, acetone, turpentine, methanol)
   - Gasoline and/or kerosene in containers
   - Lawn mower(s), chain saw(s), etc.
   - Lawn care products (fertilizer, pesticides, tree sprays)
   - Paint
   - Woodworking supplies
   - Other – Describe → 8a _______________

9. Check all chemicals that you may have had stored in that house.
   - Ammonia (bleach, Clorox)
   - Pesticides (e.g., Raid)
   - Solvents (e.g., benzene, acetone, turpentine, methanol)
   - Gasoline and/or kerosene in containers
   - Lawn mower(s), chain saw(s), etc.
   - Lawn care products (fertilizer, pesticides, tree sprays)
   - Paint
   - Woodworking supplies (e.g., varnish, turpentine)
   - Other – Describe → 9a _______________

10. Check all of the following you had in that home?
    - Air purifier (filter)
    - Air conditioner
    - Humidifier
    - Central heating - gas
    - Central heating – oil
    - Electric Heating (baseboard)
    - Central heating – other
    - Fireplace/wood stove

11. Was one or more wood stoves or fireplaces used?
    - No
    - Yes
    - Don’t know

12. Was a stove or oven used for cooking at that home?
    - None
    - Gas stove
    - Electric stove
    - Wood stove
    - Microwave

13. Evidence of water leaks indoors (check all that apply) that was present at that house:
    - Ceiling
    - Walls
    - Floor
    - Other – Describe 13a ____________
14. Proximity of that home to major road (i.e., paved road with considerable traffic):
   - 1 Immediately adjacent (closer than 1 block)
   - 2 1 to 4 blocks (less than ¼ mile)
   - 3 Greater than 4 blocks (or ¼ mile)
   - 4 Can’t tell
   - 5 Other – Describe → 14a__

15. Did you live next to or near any of the following listed below:
   - 1 Construction site
   - 2 Industrial operation (e.g., factory, etc.)
   - 3 Farm
   - 4 Golf course
   - 5 Sewage treatment plant
   - 6 Refinery
   - 7 Landfill
   - 8 Recycling/Reclamation facility
   - 9 Gas station
   - 10 Trucking/warehousing
   - 11 Other – Describe → 15a__
   - 12 Don’t know/can’t tell
   - 0 None

16. Was there clutter or excessive storage of any material or chemicals next to that home?
   - 0 No
   - 1 Yes
   - 2 Don’t know

16a If yes, check all that describe the clutter
   - 1 Accumulation of leaves, mulch, shrubs etc.
   - 2 Dumpster overflowing with perishable household trash (arising from food preparation) paper, plastic bottle (milk, juice) or cans (soda, preserved food) etc
   - 3 Empty or filled containers (with or without spills) of household products (e.g. oven cleaner, toilet bowl cleaner, tub and tile cleaner drain cleaner, floor care products etc.)
   - 4 Empty or filled containers of car care products (e.g. brake fluid, car wax, oil etc) or wood care products (glue, paint, paint stripper, primer wood preservatives etc.)
   - 5 Garden care products e.g. fertilizer, fungicide, insecticide, weed killer, herbicide etc.
   - 6 Other – Please explain 16a__

Pets

17. What types of pets live or have lived here?
   - 0 None
   - 1 Dog(s)
   - 2 Cat(s)
   - 3 Bird(s)
   - 4 Other – Describe → 17a__

Drinking Water and Tap Water

18. What was the source of your drinking and cooking water?
   - 1 private well
   - 2 city water supply
   - 3 spring
   - 4 bottled water/grocery store
   - 5 Don’t know
The following should be filled out about your hobbies and crafts such as fishing, hunting, woodworking, car repair, home remodeling, painting, etc that you were involved in prior to the diagnosis of ALS. (Do not include sports here.)

1. Do or did you have any of the following hobbies or crafts?
   - Wood working
   - Car/motorcycle/boat restoration
   - Metal working, e.g., welding or soldering metals, jewelry-making
   - Fishing and or swimming in the Great Lakes and/or inland lakes
   - Hunting, guns, shooting skeet, trap or targets.
   - Home remodeling, furniture refinishing
   - Making stained glass, pottery or ceramics
   - Photograph development (in the dark room)
   - Painting (oil and spray) pictures or other fine arts
   - Other – Please explain 1a ____________________________

2. Check any of the automobile repair you personally did on your (or others) cars or motorcycles?
   - Work on the engine, e.g. mechanical repair, oil change,
   - Detailing the body, e.g. repair, painting, waxing etc.
   - Work on the exhaust
   - Repair and maintenance, e.g., check fluids, coolant flush
   - Work with the brake /transmission/power steering fluids
   - Worked with car brakes
   - Other – Please explain 2a_______________________________

3. For other members of your household, do or did they have any of the following hobbies or crafts?
   - Wood working
   - Car/motorcycle/boat restoration
   - Metal working, e.g., welding or soldering metals, jewelry-making
   - Fishing and or swimming in the Great Lakes and/or inland lakes
   - Hunting, guns, shooting skeet, trap or targets.
   - Home remodeling, furniture refinishing
   - Making stained glass, pottery or ceramics
   - Photograph development (in the dark room)
   - Painting (oil and spray) pictures or other fine arts
   - Other – Please explain 3a ______________________________

4. Does or did a member of your household work on your car? (If a member of your household had any other hobbies 5 to 10 years ago, consider it here.)
   - No
   - Yes

4a. If yes, briefly describe what kind of work they do or did?
   - Work on the engine e.g. mechanical repair, oil change, coolant flush.
   - Detailing the body, e.g. repair, painting, waxing etc.
   - Work on the exhaust
   - Repair and maintenance, e.g., check fluids, coolants
   - Work with the brake /transmission/power steering fluids
   - Worked with car brakes
   - Other – Please explain 4a ______________________________
1. While not at work, are you currently exposed or have you been previously exposed to any of the following?

<table>
<thead>
<tr>
<th>Current exposure</th>
<th>Past exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metals</td>
<td></td>
</tr>
<tr>
<td>Dusts or fibers</td>
<td></td>
</tr>
<tr>
<td>Chemicals</td>
<td></td>
</tr>
<tr>
<td>Fumes</td>
<td></td>
</tr>
<tr>
<td>Radiation</td>
<td></td>
</tr>
<tr>
<td>Biologic agents</td>
<td></td>
</tr>
<tr>
<td>Loud noise, vibration</td>
<td></td>
</tr>
<tr>
<td>Extreme heat or cold</td>
<td></td>
</tr>
<tr>
<td>Electromagnetic fields</td>
<td></td>
</tr>
</tbody>
</table>

2. If you answered yes to any of the items above, describe it:

_____________________________________________________________________________

3. Where (location, circumstance) were you exposed? Describe

_____________________________________________________________________________

4. How often are/were you exposed?

<table>
<thead>
<tr>
<th>Rarely, e.g., once or twice in your life</th>
<th>Frequently, e.g., about weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes, e.g., 1 or 2 times per year</td>
<td>All the time, e.g., about daily</td>
</tr>
<tr>
<td>Moderately, e.g., 2 to 10 times per year</td>
<td></td>
</tr>
</tbody>
</table>

5. Do you know the names of the metals, dusts, fibers, chemicals, fumes, or radiation that you are/were exposed to?

| Metal: iron, lead, mercury, cadmium, beryllium, nickel, aluminum, arsenic, other__________ |
| Dusts: silica powder, coal dust, rock dust, wood dust, other__________________________ |
| Fibers: Asbestos, animal fiber (wool), fiberglass, other______________________________ |
| Chemicals/vapors: acids, alcohols, alkali, ammonia, benzene, phenol, chloroform, toluene |
| carbon tetrachloride, chloroprene, PCB, oils, methylene chloride (paint stripper) other |
| Fumes/Gas: welding fumes, diesel smoke, halothane (for general anesthesia), carbon |
| monoxide, phosgene, other__________________________________________________________ |
| Radiation: X-ray, radiotherapy, radioactive iodine therapy, other____________________ |
| Electromagnetic fields (power lines, transformer stations); circumstance_____________ |
| Other – Explain 5a1 ________________________________________________________________ |

6. Do any household members have contact with metals, dust, fibers, chemicals, fumes, radiation, or biologic agents that is not associated with their jobs?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>
**Occupational Profile**

**Part A:**

1. The following questions refer to your current or most recent job:

   1a. Job title ________________________________
   1b. Type of industry __________________________
   1c. Name of employer _________________________
   1d. Date job began ___________________________
   1e. Are you still working in this job? □ No □ Yes
   1f. If **no**, when did this job end? ____________

   1g. Describe this job: _________________________

2. Fill in the table below listing all jobs you have worked for three or more months, including short-term, seasonal, part-time employment, and military service.

   Begin with your most recent job. Use additional paper if necessary.

<table>
<thead>
<tr>
<th>Job No.</th>
<th>Dates of employment 2a</th>
<th>Job Title and Description of Work 2b</th>
<th>Exposures* 2c</th>
<th>Protective Equipment 2d</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*List the chemicals, dusts, fibers, fumes, radiation, biologic agents (i.e., molds or viruses) and physical agents (i.e., extreme heat, cold, vibration, or noise) that you were exposed to at this job.
<table>
<thead>
<tr>
<th>Job No.</th>
<th>Dates of employment 2a</th>
<th>Job Title and Description of Work 2b</th>
<th>Exposures* 2c</th>
<th>Protective Equipment 2d</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*List the chemicals, dusts, fibers, fumes, radiation, biologic agents (i.e., molds or viruses) and physical agents (i.e., extreme heat, cold, vibration, or noise) that you were exposed to at this job.
JOB #1

THIS IS FOR THE JOB WHERE YOU ARE CURRENTLY EMPLOYED OR YOUR MOST RECENT JOB.
Part B: Occupational Exposure History

This part should be filled out for your two most recent jobs as well as for two other jobs of the longest duration. (four copies are provided for your convenience)

1. Job being described:
   1a. Number: _____  For Office Use Only
   1b. Job name (title): ___________________________________________  DOT ________ ___________
   1c. Type of industry : ___________________________________________  SIC ________ ___________

2. What were your main tasks at this job? ______________________________________________
   ________________________________________________________________________________

3. Do you know the names of the metals, dusts, fibers, chemicals, fumes, or radiation that you are/were exposed to at this job?  □₀ No  □₁ Yes
   3a If yes, list them below, please check the appropriate box and circle the one(s) that apply.
   □₁    Metal : iron, lead, mercury, chromium, cadmium, beryllium, nickel, arsenic etc.
   □₂    Dust : silica powder, coal dust, rock dust, wood dust, etc
   □₃    Fibers: Asbestos, animal fiber (wool)
   □₄    Chemicals: acid, alcohol, alkali, ammonia, benzene, phenol, chloroform, toluene carbon tetrachloride, chloroprene, PCB
   □₅    Fumes/Gas: welding fumes, diesel smoke, halothane (for general anesthesia), carbon monoxide, phosphene gas, methane chloride (in flammable paint stripper)
   □₇    Electrical or electronic equipment or machinery.
   □₈    Electromagnetic fields (power lines, transformer stations
   □₉    Other – Explain 4a1  ________________________________________________

4. Do/did you use protective equipment such as gloves, masks, respirator, goggles, or hearing protectors?  □₀ No  □₁ Yes
   4a If yes, list the protective equipments you used below .
   □₁ Gloves
   □₂ Masks
   □₃ Respirator
   □₄ Goggles
   □₅ Coveralls
   □₆ Hearing protector (ear plugs)
   □₇ Other – Describe 4a1  ________________________________________________

5. Were you advised to use protective equipment?  □₀ No  □₁ Yes

6. Were you instructed in the use of protective equipment?  □₀ No  □₁ Yes
   6a If yes, how were you instructed? □₁ Training
   □₂ Pamphlet
   □₃ Video
   □₄ Other – Describe 6a1  ________________________

7. Did you wash your hands with solvents?  □₀ No  □₁ Yes

8. Did you smoke at the workplace?  □₀ No  □₁ Yes

9. Were you exposed to secondhand tobacco smoke at the workplace?  □₀ No  □₁ Yes
10. Did you eat at the workplace?  
   □ 0 No  □ 1 Yes

   10a If yes, where did you eat?  
   □ 1 Work station  
   □ 2 Lunch room  
   □ 3 Other – Describe 10a1_______________________________

11. Did you know of any co-workers experiencing similar or unusual symptoms?  
   [e.g. fatigue, weakness, difficulty speaking, swallowing]  □ 0 No □ 1 Yes

12. Were family members experiencing similar or unusual symptoms?  
   [e.g. fatigue, weakness, difficulty speaking, swallowing]  □ 0 No □ 1 Yes

13. Did your symptoms seem to be aggravated by a specific activity?  
   [e.g., fatigue, weakness, difficulty speaking, swallowing]  □ 0 No □ 1 Yes

14. Did your symptoms (described in questions 11, 12, 13) get either worse or better or stay the same at different places or times?  
   14a At work?  □ 0 worse  □ 1 better  □ 2 same  
   14b At home?  □ 0 worse  □ 1 better  □ 2 same  
   14c On weekends?  □ 0 worse  □ 1 better  □ 2 same  
   14d On vacation?  □ 0 worse  □ 1 better  □ 2 same

15. Did anything about your job change (such as duties, procedures, overtime)?  □ 0 No □ 1 Yes

16. At this job, did you come in contact with any of the following by breathing, touching, or ingesting (swallowing)?  □ 0 No □ 1 Yes

   16a. If yes, please check the box beside the name.  
       □ 1 Acids  □ 26 Methylene chloride  
       □ 2 Alcohols (industrial, non-beverage)  □ 27 Nickel  
       □ 3 Alkalis (e.g., lye)  □ 28 PBBs  
       □ 4 Ammonia  □ 29 PCBs  
       □ 5 Arsenic  □ 30 Perchloroethylene  
       □ 6 Asbestos  □ 31 Pesticides  
       □ 7 Benzene  □ 32 Phenol  
       □ 8 Beryllium  □ 33 Phosgene  
       □ 9 Cadmium  □ 34 Radiation  
       □ 10 Carbon tetrachloride  □ 35 Rock dust  
       □ 11 Chlorinated aphabetenes  □ 36 Silica powder (glass dust casting  
       □ 12 Chloroform  investment etc  
       □ 13 Chloroprene  □ 37 Solvents  
       □ 14 Chromates  □ 38 Styrene  
       □ 15 Coal dust  □ 39 Talc  
       □ 16 Diesel exhaust/smoke  □ 40 Toluene  
       □ 17 Dichlorobenzene  □ 41 TDI or MDI  
       □ 18 Ethylene dibromide  □ 42 Trichloroethylene  
       □ 19 Ethylene dichloride  □ 43 Trinitrotoluene (TNT)  
       □ 20 Fiberglass  □ 44 Vinyl chloride  
       □ 21 Halothane (anesthetic)  □ 45 Welding fumes  
       □ 22 Isocyanates  □ 46 X-rays  
       □ 23 Ketones  □ 47 Nitrous oxide (N2O)  
       □ 24 Lead  □ 48 Electromagnetic fields  
       □ 25 Mercury  □ 49 Other – Specify below 16a1
17. Did you get the material on your skin or clothing? □_0 No □_1 Yes
18. Were your work clothes laundered at home? □_0 No □_1 Yes
19. Did you shower at work? □_0 No □_1 Yes
20. Could you smell the chemical or material you are working with? □_0 No □_1 Yes

**Occupational Health History (Prior to ALS Diagnosis if an ALS patient)**

21. Were you ever off work for more than 1 day because of an illness related to work? □_0 No □_1 Yes □_2 Don't know

21a. If yes, which of the following describes the illness? (Check all that apply)
□_1 Fever, chills, difficulty in breathing, pain in the chest, metallic taste in the mouth
□_2 Vomiting, pain in the stomach and or watery/bloody diarrhea.
□_3 Pain, numbness or tingling (pins and needles) of hands or feet or around the mouth
□_4 Headache/dizziness/weakness/vomiting/palpitation
□_5 Rash, muscle and joint pain, flu like symptoms
□_6 Mood swing, irritability, concentration problem
□_7 Lack of coordination, muscular weakness, tremor (involuntary, rhythmic movement of a part(s) of the body)
□_8 Other – Describe 21a_1 __________________________________________

22. Were you ever advised to change jobs or tasks because of any health problems or injuries? □_0 No □_1 Yes □_2 Don't know

22a. If yes, why? Please describe __________________________________________

23. Has/did your work routine changed at this job? □_0 No □_1 Yes □_2 Don't know

23a. If yes, describe what aspect of your work changed?
□_1 Procedures
□_2 Duties
□_3 Overtime
□_4 Other – Describe 23a_1 __________________________________________

24. Is/was there poor ventilation in your workplace? □_0 No □_1 Yes □_2 Don't know

24a. If yes, check all that apply
□_1 Not enough fans for forced drafting (circulation) of air.
□_2 Not enough air ducts to convey cool air
□_3 Not enough mechanical exhaust to remove contaminated /hot air
□_4 Not enough open windows
□_5 Other – Describe 24a_1 __________________________________________
JOB #2

THIS IS FOR THE JOB YOU HAD BEFORE YOUR LAST/CURRENT JOB.
Part B: Occupational Exposure History

This part should be filled out for your two most recent jobs as well as for two other jobs of the longest duration. (four copies are provided for your convenience)

1. Job being described:
   1a. Number: ____  For Office Use Only
   1b. Job name (title): _________________________________  DOT ________ ___________
   1c. Type of industry : _________________________________  SIC ________ ___________

2. What were your main tasks at this job? ______________________________________________
   ____________________________________________________________________________

3. Do you know the names of the metals, dusts, fibers, chemicals, fumes, or radiation that you are/were exposed to at this job? □ 0 No □ 1 Yes

3a If yes, list them below, please check the appropriate box and circle the one(s) that apply.
   □ 1  Metal : iron, lead, mercury, chromium, cadmium, beryllium, nickel, arsenic etc.
   □ 2  Dust : silica powder, coal dust, rock dust, wood dust, etc
   □ 3  Fibers: Asbestos, animal fiber (wool)
   □ 4  Chemicals: acid, alcohol, alkali, ammonia, benzene, phenol, chloroform, toluene carbon tetrachloride, chloroprene, PCB
   □ 5  Fumes/Gas: welding fumes, diesel smoke, halothane (for general anesthesia), carbon monoxide, phosgene gas, methylene chloride (in flammable paint stripper)
   □ 7  Electrical or electronic equipment or machinery.
   □ 8  Electromagnetic fields (power lines, transformer stations
   □ 9  Other – Explain 4a1  ________________________________________________________

4. Do/did you use protective equipment such as gloves, masks, respirator, goggles, or hearing protectors? □ 0 No □ 1 Yes

4a If yes, list the protective equipments you used below .
   □ 1  Gloves  □ 5  Coveralls  
   □ 2  Masks  □ 6  Hearing protector (ear plugs)
   □ 3  Respirator  □ 7  Other – Describe 4a1___________
   □ 4  Goggles

5. Were you advised to use protective equipment? □ 0 No □ 1 Yes

6. Were you instructed in the use of protective equipment? □ 0 No □ 1 Yes

6a If yes, how were you instructed?□ 1  Training
   □ 2  Pamphlet  □ 4  Other – Describe 6a1 ___________
   □ 3  Video

7. Did you wash your hands with solvents? □ 0 No □ 1 Yes

8. Did you smoke at the workplace? □ 0 No □ 1 Yes

9. Were you exposed to secondhand tobacco smoke at the workplace? □ 0 No □ 1 Yes
10. Did you eat at the workplace?  □ 0 No    □ 1 Yes

10a. If yes, where did you eat?    □ 1 Work station
    □ 2 Lunch room
    □ 3 Other – Describe 10a1______________________________

11. Did you know of any co-workers experiencing similar or unusual symptoms? [e.g. fatigue, weakness, difficulty speaking, swallowing]  □ 0 No    □ 1 Yes

12. Were family members experiencing similar or unusual symptoms? [e.g. fatigue, weakness, difficulty speaking, swallowing]  □ 0 No    □ 1 Yes

13. Did your symptoms seem to be aggravated by a specific activity? [e.g., fatigue, weakness, difficulty speaking, swallowing]  □ 0 No    □ 1 Yes

14. Did your symptoms (described in questions 11, 12, 13) get either worse or better or stay the same at different places or times?
   14a. At work?  □ 0 worse    □ 1 better    □ 2 same
   14b. At home?  □ 0 worse    □ 1 better    □ 2 same
   14c. On weekends?  □ 0 worse    □ 1 better    □ 2 same
   14d. On vacation?  □ 0 worse    □ 1 better    □ 2 same

15. Did anything about your job change (such as duties, procedures, overtime)?  □ 0 No    □ 1 Yes

16. At this job, did you come in contact with any of the following by breathing, touching, or ingesting (swallowing)?  □ 0 No    □ 1 Yes

16a. If yes, please check the box beside the name.

□ 1 Acids
□ 2 Alcohols (industrial, non-beverage)
□ 3 Alkalies (e.g., lye)
□ 4 Ammonia
□ 5 Arsenic
□ 6 Asbestos
□ 7 Benzene
□ 8 Beryllium
□ 9 Cadmium
□ 10 Carbon tetrachloride
□ 11 Chlorinated aphaltalenes
□ 12 Chloroform
□ 13 Chloroprene
□ 14 Chromates
□ 15 Coal dust
□ 16 Diesel exhaust/smoke
□ 17 Dichlorobenzene
□ 18 Ethylene dibromide
□ 19 Ethylene dichloride
□ 20 Fiberglass
□ 21 Halothane (anesthetic)
□ 22 Isocyanates
□ 23 Ketones
□ 24 Lead
□ 25 Mercury
□ 26 Methylene chloride
□ 27 Nickel
□ 28 PBBs
□ 29 PCBs
□ 30 Perchloroethylene
□ 31 Pesticides
□ 32 Phenol
□ 33 Phosgene
□ 34 Radiation
□ 35 Rock dust
□ 36 Silica powder (glass dust casting investment etc
□ 37 Solvents
□ 38 Styrene
□ 39 Talc
□ 40 Toluene
□ 41 TDI or MDI
□ 42 Trichloroethylene
□ 43 Trinitrotoluene (TNT)
□ 44 Vinyl chloride
□ 45 Welding fumes
□ 46 X-rays
□ 47 Nitrous oxide (N2O)
□ 48 Electromagnetic fields
□ 49 Other – Specify below 16a1______________
17. Did you get the material on your skin or clothing?  □₀ No □₁ Yes
18. Were your work clothes laundered at home?  □₀ No □₁ Yes
19. Did you shower at work?  □₀ No □₁ Yes
20. Could you smell the chemical or material you are working with?  □₀ No □₁ Yes

**Occupational Health History (Prior to ALS Diagnosis if an ALS patient)**

21. Were you ever off work for more than 1 day because of an illness related to work?  □₀ No □₁ Yes □₂ Don’t know

21a. If yes, which of the following describes the illness? (Check all that apply)
- □₁ Fever, chills, difficulty in breathing, pain in the chest, metallic taste in the mouth
- □₂ Vomiting, pain in the stomach and or watery/bloody diarrhea.
- □₃ Pain, numbness or tingling (pins and needles) of hands or feet or around the mouth
- □₄ Headache/dizziness/weakness/vomiting/palpitation
- □₅ Rash, muscle and joint pain, flu like symptoms
- □₆ Mood swing, irritability, concentration problem
- □₇ Lack of coordination, muscular weakness, tremor (involuntary, rhythmic movement of a part(s) of the body)
- □₈ Other – Describe 21a₁ __________________________________________

22. Were you ever advised to change jobs or tasks because of any health problems or injuries?  □₀ No □₁ Yes □₂ Don’t know

22a. If yes, why? Please describe  __________________________________________________________

23. Has/did your work routine changed at this job?  □₀ No □₁ Yes □₂ Don’t know

23a. If yes, describe what aspect of your work changed?
- □₁ Procedures
- □₂ Duties
- □₃ Overtime
- □₄ Other – Describe 23a₁ __________________________________________

24. Is/was there poor ventilation in your workplace?  □₀ No □₁ Yes □₂ Don’t know

24a. If yes, check all that apply
- □₁ Not enough fans for forced drafting (circulation) of air.
- □₂ Not enough air ducts to convey cool air
- □₃ Not enough mechanical exhaust to remove contaminated /hot air
- □₄ Not enough open windows
- □₅ Other – Describe 24a₁ ____________________________________________
JOB #3

THIS IS FOR THE JOB WHERE YOU WORKED THE LONGEST THAT IS DIFFERENT THAN THE 2 JOBS THAT YOU HAVE ALREADY COMPLETED.
Part B: Occupational Exposure History

This part should be filled out for your two most recent jobs as well as for two other jobs of the longest duration. (four copies are provided for your convenience)

1. Job being described:
   1a. Number: _____ For Office Use Only
   1b. Job name (title): ____________________________ DOT ________ ___________
   1c. Type of industry: ____________________________ SIC ________ ___________

2. What were your main tasks at this job? ____________________________________________
   __________________________________________________________________________

3. Do you know the names of the metals, dusts, fibers, chemicals, fumes, or radiation that you are/were exposed to at this job? □ 0 No □ 1 Yes
   3a If yes, list them below, please check the appropriate box and circle the one(s) that apply.
   □ 1 Metal: iron, lead, mercury, chromium, cadmium, beryllium, nickel, arsenic etc.
   □ 2 Dust: silica powder, coal dust, rock dust, wood dust, etc
   □ 3 Fibers: Asbestos, animal fiber (wool)
   □ 4 Chemicals: acid, alcohol, alkali, ammonia, benzene, phenol, chloroform, toluene carbon tetrachloride, chloroprene, PCB
   □ 5 Fumes/Gas: welding fumes, diesel smoke, halothane (for general anesthesia), carbon monoxide, phosgene gas, methylene chloride (in flammable paint stripper)
   □ 7 Electrical or electronic equipment or machinery.
   □ 8 Electromagnetic fields (power lines, transformer stations
   □ 9 Other – Explain 4a1 ________________________________

4. Do/did you use protective equipment such as gloves, masks, respirator, goggles, or hearing protectors? □ 0 No □ 1 Yes
   4a If yes, list the protective equipments you used below .
   □ 1 Gloves □ 5 Coveralls
   □ 2 Masks □ 6 Hearing protector (ear plugs)
   □ 3 Respirator □ 7 Other – Describe 4a1 ___________
   □ 4 Goggles

5. Were you advised to use protective equipment? □ 0 No □ 1 Yes

6. Were you instructed in the use of protective equipment? □ 0 No □ 1 Yes
   6a If yes, how were you instructed? □ 1 Training
   □ 2 Pamphlet □ 4 Other – Describe 6a1 ___________
   □ 3 Video

7. Did you wash your hands with solvents? □ 0 No □ 1 Yes

8. Did you smoke at the workplace? □ 0 No □ 1 Yes

9. Were you exposed to secondhand tobacco smoke at the workplace? □ 0 No □ 1 Yes
10. Did you eat at the workplace?  □ 0 No  □ 1 Yes

10a If yes, where did you eat?  □ 1 Work station  □ 2 Lunch room  □ 3 Other – Describe 10a1______________________________

11. Did you know of any co-workers experiencing similar or unusual symptoms? [e.g. fatigue, weakness, difficulty speaking, swallowing]  □ 0 No  □ 1 Yes

12. Were family members experiencing similar or unusual symptoms? [e.g. fatigue, weakness, difficulty speaking, swallowing]  □ 0 No  □ 1 Yes

13. Did your symptoms seem to be aggravated by a specific activity? [e.g., fatigue, weakness, difficulty speaking, swallowing]  □ 0 No  □ 1 Yes

14. Did your symptoms (described in questions 11, 12, 13) get either worse or better or stay the same at different places or times?
   14a At work?  □ 0 worse  □ 1 better  □ 2 same
   14b At home?  □ 0 worse  □ 1 better  □ 2 same
   14c On weekends?  □ 0 worse  □ 1 better  □ 2 same
   14d On vacation?  □ 0 worse  □ 1 better  □ 2 same

15. Did anything about your job change (such as duties, procedures, overtime)?  □ 0 No  □ 1 Yes

16. At this job, did you come in contact with any of the following by breathing, touching, or ingesting (swallowing)?  □ 0 No  □ 1 Yes

16a. If yes, please check the box beside the name.

□ 1 Acids
□ 2 Alcohols (industrial, non-beverage)
□ 3 Alkalies (e.g., lye)
□ 4 Ammonia
□ 5 Arsenic
□ 6 Asbestos
□ 7 Benzene
□ 8 Beryllium
□ 9 Cadmium
□ 10 Carbon tetrachloride
□ 11 Chlorinated aphthalenes
□ 12 Chloroform
□ 13 Chloroprene
□ 14 Chromates
□ 15 Coal dust
□ 16 Diesel exhaust/smoke
□ 17 Dichlorobenzene
□ 18 Ethylene dibromide
□ 19 Ethylene dichloride
□ 20 Fiberglass
□ 21 Halothane (anesthetic)
□ 22 Isocyanates
□ 23 Ketones
□ 24 Lead
□ 25 Mercury
□ 26 Methylene chloride
□ 27 Nickel
□ 28 PBBs
□ 29 PCBs
□ 30 Perchloroethylene
□ 31 Pesticides
□ 32 Phenol
□ 33 Phosgene
□ 34 Radiation
□ 35 Rock dust
□ 36 Silica powder (glass dust casting investment etc
□ 37 Solvents
□ 38 Styrene
□ 39 Talc
□ 40 Toluene
□ 41 TDI or MDI
□ 42 Trichloroethylene
□ 43 Trinitrotoluene (TNT)
□ 44 Vinyl chloride
□ 45 Welding fumes
□ 46 X-rays
□ 47 Nitrous oxide (N2O)
□ 48 Electromagnetic fields
□ 49 Other – Specify below 16a1
17. Did you get the material on your skin or clothing? □ 0 No □ 1 Yes

18. Were your work clothes laundered at home? □ 0 No □ 1 Yes

19. Did you shower at work? □ 0 No □ 1 Yes

20. Could you smell the chemical or material you are working with? □ 0 No □ 1 Yes

**Occupational Health History (Prior to ALS Diagnosis if an ALS patient)**

21. Were you ever off work for more than 1 day because of an illness related to work? □ 0 No □ 1 Yes □ 2 Don’t know

21a. If yes, which of the following describes the illness? (Check all that apply)
□ 1 Fever, chills, difficulty in breathing, pain in the chest, metallic taste in the mouth
□ 2 Vomiting, pain in the stomach and or watery/bloody diarrhea.
□ 3 Pain, numbness or tingling (pins and needles) of hands or feet or around the mouth
□ 4 Headache/dizziness/weakness/vomiting/palpitation
□ 5 Rash, muscle and joint pain, flu like symptoms
□ 6 Mood swing, irritability, concentration problem
□ 7 Lack of coordination, muscular weakness, tremor (involuntary, rhythmic movement of a part(s) of the body)
□ 8 Other – Describe 21a1 ______________________________

22. Were you ever advised to change jobs or tasks because of any health problems or injuries? □ 0 No □ 1 Yes □ 2 Don’t know

22a. If yes, why? Please describe ______________________________________________________

23. Has/did your work routine changed at this job? □ 0 No □ 1 Yes □ 2 Don’t know

23a. If yes, describe what aspect of your work changed?
□ 1 Procedures
□ 2 Duties
□ 3 Overtime
□ 4 Other – Describe 23a1 ______________________________

24. Is/was there poor ventilation in your workplace? □ 0 No □ 1 Yes □ 2 Don’t know

24a. If yes, check all that apply
□ 1 Not enough fans for forced drafting (circulation) of air.
□ 2 Not enough air ducts to convey cool air
□ 3 Not enough mechanical exhaust to remove contaminated /hot air
□ 4 Not enough open windows
□ 5 Other – Describe 24a1 _________________________________
JOB #4

THIS IS FOR THE JOB YOU WORKED AT THE NEXT LONGEST THAT IS DIFFERENT THAN THE 3 ALREADY COMPLETED.
Part B: Occupational Exposure History

This part should be filled out for your two most recent jobs as well as for two other jobs of the longest duration. (four copies are provided for your convenience)

1. Job being described:
   1a. Number: ____  For Office Use Only
   1b. Job name (title): _______________________________  DOT ________ ________
   1c. Type of industry: _______________________________  SIC ________ ________

2. What were your main tasks at this job? __________________________________________
   __________________________________________

3. Do you know the names of the metals, dusts, fibers, chemicals, fumes, or radiation that you are/were exposed to at this job?  □ 0  No  □ 1  Yes

   3a If yes, list them below, please check the appropriate box and circle the one(s) that apply.
      □ 1  Metal : iron, lead, mercury, chromium, cadmium, beryllium, nickel, arsenic etc.
      □ 2  Dust : silica powder, coal dust, rock dust, wood dust, etc
      □ 3  Fibers: Asbestos, animal fiber (wool)
      □ 4  Chemicals: acid, alcohol, alkali, ammonia, benzene, phenol, chloroform, toluene carbon tetrachloride, chloroprene, PCB
      □ 5  Fumes/Gas: welding fumes, diesel smoke, halothane (for general anesthesia), carbon monoxide, phosgene gas, methylene chloride (in flammable paint stripper)
      □ 7  Electrical or electronic equipment or machinery.
      □ 8  Electromagnetic fields (power lines, transformer stations
      □ 9  Other – Explain 4a1  __________________________________________

4. Do/did you use protective equipment such as gloves, masks, respirator, goggles, or hearing protectors?  □ 0  No  □ 1  Yes

   4a If yes, list the protective equipments you used below .
      □ 1  Gloves  □ 5  Coveralls
      □ 2  Masks  □ 6  Hearing protector (ear plugs)
      □ 3  Respirator  □ 7  Other – Describe 4a1  __________________________________________
      □ 4  Goggles

5. Were you advised to use protective equipment?  □ 0  No  □ 1  Yes

6. Were you instructed in the use of protective equipment?  □ 0  No  □ 1  Yes

   6a If yes, how were you instructed? □ 1  Training
      □ 2  Pamphlet  □ 4  Other – Describe 6a1  __________________________
      □ 3  Video

7. Did you wash your hands with solvents?  □ 0  No  □ 1  Yes

8. Did you smoke at the workplace?  □ 0  No  □ 1  Yes

9. Were you exposed to secondhand tobacco smoke at the workplace?  □ 0  No  □ 1  Yes
10. Did you eat at the workplace?  
   □ 0  No  □ 1  Yes

10a. If yes, where did you eat?  
   □ 1  Work station  
   □ 2  Lunch room  
   □ 3  Other – Describe 10a1______________________________

11. Did you know of any co-workers experiencing similar or unusual symptoms?  
   [e.g. fatigue, weakness, difficulty speaking, swallowing]  
   □ 0  No  □ 1  Yes

12. Did you know of any co-workers experiencing similar or unusual symptoms?  
   [e.g. fatigue, weakness, difficulty speaking, swallowing]  
   □ 0  No  □ 1  Yes

13. Did you know of any co-workers experiencing similar or unusual symptoms?  
   [e.g. fatigue, weakness, difficulty speaking, swallowing]  
   □ 0  No  □ 1  Yes

14. Did your symptoms seem to be aggravated by a specific activity?  
   [e.g., fatigue, weakness, difficulty speaking, swallowing]  
   □ 0  No  □ 1  Yes

14a. If yes, at work?  
   □ 0  worse  □ 1  better  □ 2  same

14b. If yes, at home?  
   □ 0  worse  □ 1  better  □ 2  same

14c. If yes, on weekends?  
   □ 0  worse  □ 1  better  □ 2  same

14d. If yes, on vacation?  
   □ 0  worse  □ 1  better  □ 2  same

15. Did anything about your job change (such as duties, procedures, overtime)?  
   □ 0  No  □ 1  Yes

16. At this job, did you come in contact with any of the following by breathing, touching, or ingesting (swallowing)?  
   □ 0  No  □ 1  Yes

16a. If yes, please check the box beside the name.

□ 1  Acids
□ 2  Alcohols (industrial, non-beverage)
□ 3  Alkalies (e.g., lye)
□ 4  Ammonia
□ 5  Arsenic
□ 6  Asbestos
□ 7  Benzene
□ 8  Beryllium
□ 9  Cadmium
□ 10  Carbon tetrachloride
□ 11  Chlorinated aphantalenes
□ 12  Chloroform
□ 13  Chloroprene
□ 14  Chromates
□ 15  Coal dust
□ 16  Diesel exhaust/smoke
□ 17  Dichlorobenzene
□ 18  Ethylene dibromide
□ 19  Ethylene dichloride
□ 20  Fiberglass
□ 21  Halothane (anesthetic)
□ 22  Isocyanates
□ 23  Ketones
□ 24  Lead
□ 25  Mercury
□ 26  Methylene chloride
□ 27  Nickel
□ 28  PBBs
□ 29  PCBs
□ 30  Perchloroethylene
□ 31  Pesticides
□ 32  Phenol
□ 33  Phosgene
□ 34  Radiation
□ 35  Rock dust
□ 36  Silica powder (glass dust casting investment etc
□ 37  Solvents
□ 38  Styrene
□ 39  Talc
□ 40  Toluene
□ 41  TDI or MDI
□ 42  Trichloroethylene
□ 43  Trinitrotoluene (TNT)
□ 44  Vinyl chloride
□ 45  Welding fumes
□ 46  X-rays
□ 47  Nitrous oxide (N₂O)
□ 48  Electromagnetic fields
□ 49  Other – Specify below 16a1
17. Did you get the material on your skin or clothing? □ 0 No □ 1 Yes
18. Were your work clothes laundered at home? □ 0 No □ 1 Yes
19. Did you shower at work? □ 0 No □ 1 Yes
20. Could you smell the chemical or material you are working with? □ 0 No □ 1 Yes

Occupational Health History (Prior to ALS Diagnosis if an ALS patient)

21. Were you ever off work for more than 1 day because of an illness related to work? □ 0 No □ 1 Yes □ 2 Don’t know
21a. If yes, which of the following describes the illness? (Check all that apply)
   □ 1 Fever, chills, difficulty in breathing, pain in the chest, metallic taste in the mouth
   □ 2 Vomiting, pain in the stomach and or watery/bloody diarrhea.
   □ 3 Pain, numbness or tingling (pins and needles) of hands or feet or around the mouth
   □ 4 Headache/dizziness/weakness/vomiting/palpitation
   □ 5 Rash, muscle and joint pain, flu like symptoms
   □ 6 Mood swing, irritability, concentration problem
   □ 7 Lack of coordination, muscular weakness, tremor (involuntary, rhythmic movement of a part(s) of the body)
   □ 8 Other – Describe 21a1 ____________________________
22. Were you ever advised to change jobs or tasks because of any health problems or injuries? □ 0 No □ 1 Yes □ 2 Don’t know
22a. If yes, why? Please describe __________________________________________________
23. Has/did your work routine changed at this job? □ 0 No □ 1 Yes □ 2 Don’t know
23a. If yes, describe what aspect of your work changed?
   □ 1 Procedures
   □ 2 Duties
   □ 3 Overtime
   □ 4 Other – Describe 23a1 ______________________________
24. Is/was there poor ventilation in your workplace? □ 0 No □ 1 Yes □ 2 Don’t know
24a. If yes, check all that apply
   □ 1 Not enough fans for forced drafting (circulation) of air.
   □ 2 Not enough air ducts to convey cool air
   □ 3 Not enough mechanical exhaust to remove contaminated /hot air
   □ 4 Not enough open windows
   □ 5 Other – Describe 24a1 _________________________________
THE FOLLOWING QUESTIONS ARE REGARDING SERVICES WITH THE BRANCHES OF THE UNITED STATES ARMED FORCES.

1. Did you ever *(during your life time)* work in the US armed forces as an enlisted personnel or civilian personnel?
   - ☐ 1 Enlisted personnel
   - ☐ 2 Civilian personnel
   - ☐ 3 Neither

*If neither, please continue to the next section (Use of Tobacco)*

2. How old were you when you first started working in the Armed forces? _________ (age)

3. Are you still working in the armed forces? ☐ 0 No ☐ 1 Yes

4. If you are no longer working with the armed forces, when did you retire? If you cannot remember the year give us the age when you retired?
   - ____________ (year)
   - ____________ (age)

5. For how long are you serving (did you serve) in the armed forces? ____________ (year)

6. In which branch of the armed forces do (did) you serve?
   - ☐ 1 Army
   - ☐ 2 Navy
   - ☐ 3 Air force
   - ☐ 4 Marine
   - ☐ 5 National guard
   - ☐ 6 Other – Describe 6a _________________________

7. What is (was) your rank(s)? Please list all that apply.
   - ☐ 1 Private
   - ☐ 2 Corporal
   - ☐ 3 Petty officer
   - ☐ 4 Sergeant
   - ☐ 5 Lieutenant
   - ☐ 6 Captain
   - ☐ 7 Major
   - ☐ 8 Lieutenant commander
   - ☐ 9 Colonel /Lieutenant Colonel
   - ☐ 10 Commander
   - ☐ 11 Admiral/General
   - ☐ 12 Other – Describe 7a _______________________________
8. While serving in the forces are (were) you ever exposed to any of the following?
(Please go through the list carefully before you answer and list all that apply)

- Munitions and related materials
- Decontamination kits
- Radioactive waste
- Waste oils and fuel, organic solvents, spent process chemicals, lubricants.
- Chemical warfare agents e.g. mustard agent, arsines, hydrogen cyanide other
- Smoke grenades
- Propellants, pyrotechnics, demolition charges,
- Smoke from oil wells
- Sarine, Tabun or other nerve gases
- Self administered antidotes to nerve agents (Pyridostigmine bromide/PB)
- Insecticides and repellents (chlorpyrifos, DEET)
- Jet fuel exhaust and related aromatic hydrocarbon e.g. benzene, toluene etc.
- Extreme heat, dehydration and prolonged intense physical exertion.
- Diesel exhaust.
- Other – Describe 8a

9. How often are (were) you exposed?

- Rarely
- Sometimes
- Moderately
- Frequently
- All the time

10. Please list all the places where you were deployed to and the duration of each deployment?

<table>
<thead>
<tr>
<th>Location</th>
<th>Duration (in months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st deployment</td>
<td></td>
</tr>
<tr>
<td>2nd deployment</td>
<td></td>
</tr>
<tr>
<td>3rd deployment</td>
<td></td>
</tr>
<tr>
<td>4th deployment</td>
<td></td>
</tr>
<tr>
<td>5th deployment</td>
<td></td>
</tr>
<tr>
<td>Never deployed</td>
<td></td>
</tr>
</tbody>
</table>
The following is about your tobacco use.

1. Have you ever smoked/used tobacco?  □_0_ No  □_1_ Yes
   Type of tobacco use:
   □ Cigarette
   □ Cigar
   □ Pipe
   □ Chewing tobacco
   □ Snuff

   If No, skip to next section

2. If yes, when did you start smoking/using  ______ year

3. Are you a current smoker/user  □_0_ No  □_1_ Yes

4. If no, when did you quit  ______ year

5. If Cigarettes, how many packs per day did you smoke at the most?  ______ packs/day

6. If other forms of tobacco use(d), how much per day smoked/used? (Be Specific)  _______________

   ____________________________________________  __________________________ per day
The following is about your exercise patterns about 5 years ago

1. How often did you walk a mile or more at a time without stopping? _______ times per month

The next questions are about your leisure time physical activity. We are interested in the following exercises, sports, or physically active hobbies that you might have done. Again, this applies to a period of 5 years ago.

Did you...

2a. Jog or run?
   ☐ 1 Yes If yes,  2a₁ ________ times per month
   ☐ 0 No ________ times per year

2b. Ride a bicycle or an exercise bicycle?
   ☐ 1 Yes If yes,  2b₁ ________ times per month
   ☐ 0 No ________ times per year

2c. Swim?
   ☐ 1 Yes If yes,  2c₁ ________ times per month
   ☐ 0 No ________ times per year

2d. Do aerobics or aerobic dancing?
   ☐ 1 Yes If yes,  2d₁ ________ times per month
   ☐ 0 No ________ times per year

2e. Do recreational dancing?
   ☐ 1 Yes If yes,  2e₁ ________ times per month
   ☐ 0 No ________ times per year

2f. Do calisthenics or exercises?
   ☐ 1 Yes If yes,  2f₁ ________ times per month
   ☐ 0 No ________ times per year

2g. Do gardening or yard work?
   ☐ 1 Yes If yes,  2g₁ ________ times per month
   ☐ 0 No ________ times per year
2h. Lift weights?
☐ 1 Yes  If yes,  2h₁ times per month
☐ 0 No  times per year

2i. Play soccer, football, baseball, field hockey or golf?
☐ 1 Yes  If yes,  2i₁ times per month
☐ 0 No  times per year

2j. Play ice hockey, tennis, boxing or wrestling?
☐ 1 Yes  If yes,  2j₁ times per month
☐ 0 No  times per year

2k. Do any other exercises, sports, or physically active hobbies not mentioned?
☐ 0 No  ☐ 1 Yes

2k₁ If yes, please specify:

1st other activity Please Specify  How many times per month?  
                              months per year?  

2nd other activity Please Specify  How many times per month?  
                              months per year?  

3rd other activity Please Specify  How many times per month?  
                              months per year?  

4th other activity Please Specify  How many times per month?  
                              months per year?  

3. Five years ago, compared with most men/women your age, would you say that you are more active, less active, or about the same?
☐ 1 More active  ☐ 3 About the same
☐ 2 Less active  ☐ 4 Don’t know

4. What is your current height?  _______ feet _____ inches

5. What is your current weight?  _______ pounds

6. About five years ago, what did you weigh?  _______ pounds

7. About ten years ago, what did you weigh?  _______ pounds

******************************************************************************End of Survey******************************************************************************
We thank you very much for completing the survey! Because we want to be able to use all the information you have provided we would greatly appreciate it if you would please take a moment to review each page making sure that you did not skip any pages and crossed out the incorrect answer and checked the correct answer if you made any changes.

OTHER INFORMATION

Are there any questions or information that you think we should have asked you?

☐ Yes  ☐ No  ☐ Don’t know

If you answered Yes, please explain: _________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Additional comments or suggestions?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Thank you very much for completing the survey/questionnaire!