

Environmental Action for Children's Health

Household ID No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Initials of Respondent <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Initials of Surveyor <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>

Start Time _____

Completion Time _____

Resident Survey of Home Environment

Participant Demographic Information

Please indicate your ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Please indicate your racial background: (NOTE: check ALL that apply) : <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White
What is the yearly income for your family? <input type="checkbox"/> < \$20,000 <input type="checkbox"/> \$20,000 – \$40,000 <input type="checkbox"/> \$40,000 – \$60,000 <input type="checkbox"/> > \$60,000	

General Information

	Comments
Do you own or rent your home? <input type="checkbox"/> Own <input type="checkbox"/> Rent	
How many people live here? _____ How many are < 6 yrs old? _____ Do any children < 6 yrs visit or play here? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How many bedrooms are there in the home? _____ How many bathrooms are there? _____	
When was the home built (approximate)? _____	
How long have you lived at this address? _____ yrs	
Have any rooms been painted in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No Was old paint disturbed by scraping/sanding? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not certain	
Have you made any other home improvements in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No What was done to the home? _____	
In the past 12 months, has there been a fire in this home? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what was the cause of the fire? _____	

General Home Conditions

	Comments
Do you ever use a space heater in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you ever use your kitchen stove for heat? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What type of cooking stove do you use? <input type="checkbox"/> Electric <input type="checkbox"/> Gas <input type="checkbox"/> Other _____	
Are you aware of any of the following: <input type="checkbox"/> Water leaks <input type="checkbox"/> Broken windows <input type="checkbox"/> Broken plaster <input type="checkbox"/> Peeling paint or wallpaper	
Have you noticed any of the following in the home <input type="checkbox"/> Rodents <input type="checkbox"/> Rodent nests <input type="checkbox"/> Rodent droppings <input type="checkbox"/> Cockroaches <input type="checkbox"/> Cockroach feces <input type="checkbox"/> Holes in walls/floors related to rodents or insects	
Is there any evidence of moisture, water damage or leaks: ...in the kitchen? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not certain ...in the bathroom(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not certain ...in the laundry? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not certain ...other rooms? (list) _____ _____ _____ _____	
Have you noticed a smell of mold or must in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Home Furnishings

	Comments
Do you have air-conditioning in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: What type <input type="checkbox"/> Central <input type="checkbox"/> Window Is it cleaned regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use fans in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: What type <input type="checkbox"/> Ceiling <input type="checkbox"/> Window <input type="checkbox"/> Room Is it cleaned regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use a humidifier/vaporizer? <input type="checkbox"/> Yes <input type="checkbox"/> No Is it cleaned regularly? _____	

<p>Do you use a dehumidifier? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, How is it emptied? <input type="checkbox"/> Drain <input type="checkbox"/> Container Is it cleaned regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Do you have a vacuum cleaner? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, _____mfg. _____model Type of vacuum cleaner filtration system: <input type="checkbox"/> Water <input type="checkbox"/> Bag <input type="checkbox"/> Other: _____</p>	

Lifestyle and Living Space

Comments

<p>Does anyone who lives in the home smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many smokers are there? _____ Where do they smoke? <input type="checkbox"/> Outside <input type="checkbox"/> Inside <input type="checkbox"/> Both Do they use a smoking jacket? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Do visitors smoke in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often are they here? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month <input type="checkbox"/> Infrequently</p>	
<p>Do you burn candles or incense in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Do you use room fresheners in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Where do you store your cleaning products? <input type="checkbox"/> Kitchen <input type="checkbox"/> Bathroom <input type="checkbox"/> Basement <input type="checkbox"/> Garage</p>	
<p>Have you used insecticides in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: What was the pest? <input type="checkbox"/> Cockroaches <input type="checkbox"/> Rodents <input type="checkbox"/> Other _____ What type of insecticide <input type="checkbox"/> Pest strip <input type="checkbox"/> Powder <input type="checkbox"/> Roach motel <input type="checkbox"/> Mothballs <input type="checkbox"/> Gel <input type="checkbox"/> Pellet <input type="checkbox"/> Pest spray <input type="checkbox"/> Stick-on <input type="checkbox"/> Other _____ Who applied the insecticide? <input type="checkbox"/> Yourself <input type="checkbox"/> Landlord <input type="checkbox"/> Licensed professional</p>	

<p>How often do you dust your home?</p> <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month <input type="checkbox"/> Infrequently	
<p>Does your family have any pets? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: What type of pets? <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Bird <input type="checkbox"/> Rodents <input type="checkbox"/> Reptile <input type="checkbox"/> Fish Is the aquarium kept covered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____</p> <p>How many pets (total number) are there? _____</p> <p>Where are pets allowed to be in your home? _____</p> <p>Where do your pets sleep? _____</p> <p>Where do you store the pet food? _____</p> <p>Do you remove the pet food and water each night? _____</p>	

Home and Child Safety

Comments

<p>Do you have smoke detectors in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Do you have a carbon monoxide detector in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>At what temperature is your hot water? _____ degrees</p>	
<p>IF CHILDREN UNDER 6: Do you have safety locks on cabinets and drawers: in the kitchen <input type="checkbox"/> Yes <input type="checkbox"/> No in the bathroom <input type="checkbox"/> Yes <input type="checkbox"/> No where cleaning supplies are stored <input type="checkbox"/> Yes <input type="checkbox"/> No where medications are stored <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have childproof openers on your door handles? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have childproof covers on your electric outlets? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use gates to protect your children from stairs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

Hazard Information

	Comments
<p>In the past 6 months has anyone in your household:</p> <input type="checkbox"/> been suspected of carbon monoxide poisoning? <input type="checkbox"/> hurt themselves in a fall Where/How? _____ <input type="checkbox"/> been accidentally burned How? _____ <input type="checkbox"/> accidentally received an electric shocked How? _____ <input type="checkbox"/> accidentally poisoned How? _____	
<p>In the past 6 months has anyone living here worked or participated in hobbies involving lead? (Examples: Auto body work, Welding, Plumbing, Construction, Industrial painting, Ceramics, Stained Glass)</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>In the past 6 months has anyone living here worked at a job involving the application of pesticides or other chemicals?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	

General Family Health (Persons OTHER than the child with asthma)

	Comments
<p>In the past 6 months, has any one else in your family experienced:</p> <input type="checkbox"/> frequent cough without a cold About how often _____ <input type="checkbox"/> breathing difficulties About how often _____ <input type="checkbox"/> runny nose About how often _____ <input type="checkbox"/> itchy eyes About how often _____ <input type="checkbox"/> skin rash or irritation About how often _____ <input type="checkbox"/> persistent stomach aches About how often _____ <input type="checkbox"/> headache/nausea/dizziness About how often _____	
<p>In the past 6 months, how many times have persons in your family stayed home from work or school because of illness? _____ times</p>	
<p>In the past 6 months, about how many days were other persons in your family sick? _____ times</p>	
<p>In the past 6 months has any one else in your family been:</p> <input type="checkbox"/> hospitalized # of times _____ <input type="checkbox"/> received care in an emergency room # of times _____ <input type="checkbox"/> received care in an urgent care center # of times _____ <input type="checkbox"/> had an appointment with a doctor because of illness # of times _____	

ASTHMA SYMPTOMS AND QUALITY OF LIFE

I have a few more questions to ask you. These questions are about your child's asthma symptoms.

When you think about the last **FOUR** weeks how often has:

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Your child complained of being short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exertion (such as running) made your child breathless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your child coughed at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your child been woken up by wheezing or coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your child stayed indoors because of wheezing or coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your child's education suffered due to his/her asthma (during school)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your child's asthma interfered with his/her life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma limited your child's activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking his/her inhaler or other treatments interrupted your child's life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You had to made adjustments to family life because of your child's asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>