Baseline Questionnaire

Subject ID: _____

Date Completed: _____

Instructions: Please answer each of the following questions to the best of your ability. You are free to refuse to answer any questions that you don't want to.

ALL RESPONSES TO THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL, AND WILL NEVER BE VIEWED BY ANY ALCOA EMPLOYEE. MAINTAINING YOUR PRIVACY IS OUR TOP PRIORITY.

PART I- DEMOGRAPHIC INFORMATION

SEX: Male [ ] Female [ ]

HEIGHT: _____ft_____in **WEIGHT**_____lbs

EYE COLOR: Blue [ ] Green [ ] Brown [ ] Other [ ]

HAIR COLOR: Blonde [ ] Auburn [ ] Black [ ] Brown [ ]Other [ ] _____

MARITAL STATUS: Single [ ] Married [ ] Divorced/Separated [ ] Widowed [ ]

RACE (check one):
White/Caucasian [ ] Black/ African American [ ] Hawaiian Pacific Islander [ ]
Asian American [ ] Native American [ ] Other [ ]

ETHNICITY (check one): Hispanic [ ] Non Hispanic [ ]

PRIMARY LANGUAGE SPOKEN AT HOME: English [ ] Spanish [ ] French [ ] Other [ ]

HANDEDNESS: Left handed [ ] Right handed [ ] Both [ ]

DO YOU SUNTAN EASILY: Yes [ ] No [ ]

Subject ID_____

PART II- HEARING HISTORY

1. Do you have a history of ear aches/or ear infections:

as a child (under 18 yrs of age)? Yes [ ] No [ ] Not Sure [ ]
as an adult (18 yrs or older)? Yes [ ] No [ ] Not Sure [ ]

2. Have you ever had ear surgery? Yes [ ] No [ ] Not Sure [ ]

→ **If NO or NOT SURE, Skip to Question 3.**

→ **If YES, please answer the following:**

2a. Which ear? Right [ ] Left [ ] Both [ ]

2b. Year of surgery _____

2c. Type of surgery: _____

3. Have you ever had an ear injury (including exposure to traumatic explosions/ blasts)?

Yes [ ] No [ ] Not Sure [ ]

→ **If NO or NOT SURE, Skip to Question 4.**

→ **If YES, please answer the following:**

3a. Which ear? Right [ ] Left [ ] Both [ ]

3b. Year of injury: _____

3c. Explain/Describe: _____

4. Have you ever had a head injury? Yes [ ] No [ ] Not Sure [ ]

→ **If NO or NOT SURE, Skip to Question 5.**

→ **If YES, please answer the following:**

4a. Year of injury: _____

4b. Explain/Describe: _____

5. Have you ever had tinnitus (ringing in the ears)? Yes [ ] No [ ] Not Sure [ ]

→ **If NO or NOT SURE, Skip to Question 6.**

→ **If YES, please answer the following:**

Subject ID_____

5a. CIRCLE the number that best describes you:

	Never	Rarely	Sometimes	Usually	Always
Has your tinnitus					
Made it uncomfortable to be in a quiet room?	1	2	3	4	5
Made you feel irritable or nervous?	1	2	3	4	5
Made you feel tired or stressed?	1	2	3	4	5
Made it difficult for you to relax?	1	2	3	4	5
Made it difficult to concentrate?	1	2	3	4	5
Made it harder to interact pleasantly with others?	1	2	3	4	5
Does tinnitus . . .					
Interfere with your social activities or other things you do in your leisure time?	1	2	3	4	5
Interfere with your required activities (work, home care, other types of responsibilities)?	1	2	3	4	5
Interfere with your overall enjoyment of life?	1	2	3	4	5
Cause you to have difficulty sleeping?	1	2	3	4	5
How often is it difficult for you to ignore your tinnitus?	1	2	3	4	5
How often do you experience discomfort from tinnitus?	1	2	3	4	5

5b. CIRCLE the number that best describes the loudness of your usual tinnitus on the scale below:

0	1	2	3	4	5	6	7	8	9	10
Very Quiet				Intermediate						Very Loud

6. Have you ever had any unexpected problems with balance? Yes [ ] No [ ] Not Sure [ ]

→ **If NO, skip to Question 7. If YES, please answer the following:**

6a. If YES, have you experienced any of these symptoms?

lightheadedness or faintness Yes [ ] No [ ] Not Sure [ ]
unsteadiness Yes [ ] No [ ] Not Sure [ ]
vertigo (spinning)? Yes [ ] No [ ] Not Sure [ ]
falling frequently? Yes [ ] No [ ] Not Sure [ ]

6b. If YES, have you been treated for this? Yes [ ] No [ ]

Give cause, if known _____

7. Self assessment of hearing: Good [ ] Fair [ ] Poor [ ]

7a. Which statement best describes your ability to hear with your LEFT ear (without a hearing aid)?

Good [ ] Little Trouble [ ] Lot of Trouble [ ] Deaf [ ]

7b. Which statement best describes your ability to hear with your RIGHT ear (without a hearing aid)?

Good [ ] Little Trouble [ ] Lot of Trouble [ ] Deaf [ ]

7c. Do you have difficulty understanding group conversation (without a hearing aid)? Yes [ ] No[ ]

7d. If your hearing is not good, at what age did you first notice a hearing loss? _____

Subject ID_____

Did this loss begin: Gradually [ ] Suddenly [ ]

Give cause, if known_____

8. Do you wear a hearing aid? Yes [ ] No [ ]

→ **If NO, skip to Question 9.**

8a. If YES, do you wear it at work? Always [ ] Usually[ ] Occasionally [ ] Never [ ]

8b. Which ear? Right [ ] Left [ ] Both [ ]

9. Do you have any relatives with hearing loss? Yes [ ] No [ ] Not Sure [ ]

→ **If NO or NOT SURE, skip to Question 6.**

→ **If YES, please indicate the following:**

Relationship (e.g. mother, brother, uncle)	**Cause, if known**	**Age of loss, if known**

PART II- HEARING PROTECTION USE

10. While at work, how often do you wear your hearing protection?

Always [ ] Usually[ ] Occasionally [ ] Rarely [ ] Never [ ]

→ **How well do you feel that your hearing protection protects you from noise, on average?**

Underprotects (filters out too little noise) [ ] Right amount of protection [ ]
Overprotects (filters out too much noise) [ ]

11. On average, how long do you wear your hearing protection during your work shift?
_____ hours

→ **On average, how long is your typical work shift?** _____hrs

12. On average, how many times a day do you remove and put your hearing protection back in?
_____times

13. Does your hearing protection cause discomfort? Yes [ ] No [ ]

→ **If NO, Skip to Question 15.**

→ **If YES, was/is the discomfort in one ear or both ears?**

Left ear only [ ] Right ear only [ ] Both ears [ ] Not Applicable [ ]

Subject ID_____

14. If your hearing protection causes ear discomfort…:

14a. Please check the TYPE of discomfort and CIRCLE the frequency you experience it below:

Type of Discomfort		Never	Rarely	Sometimes	Usually	Always
Itching	Yes [ ] No [ ]	1	2	3	4	5
Pain	Yes [ ] No [ ]	1	2	3	4	5
Annoyance	Yes [ ] No [ ]	1	2	3	4	5
Other (describe)_____ _	Yes [ ] No [ ]	1	2	3	4	5

14b. Please CIRCLE the SEVERITY of your discomfort on a scale of 1-10, with 1 being MILD and 10 being SEVERE:

Type of Discomfort	Severity Scale Mild					Moderate				Severe
Itching	1	2	3	4	5	6	7	8	9	10
Pain	1	2	3	4	5	6	7	8	9	10
Annoyance	1	2	3	4	5	6	7	8	9	10
Other (describe)_____ _____	1	2	3	4	5	6	7	8	9	10

14c. IF you checked that your hearing protection is ANNOYING, please describe why below:

_____

15. Please check the PRIMARY type of hearing protection that you use, and list the model if known:

a.Type:	b. Model, if known:
Insert Ear Plugs [ ]	
Custom Molded [ ]	
Muffs [ ]	
Canal Caps [ ]	
Other _____ [ ]	

16. Do you ever use more than one type of hearing protection at a time? Yes [ ] No [ ]

→ If NO, Skip to Question 17.

16a. If YES, estimate the average amount of time during the workday that you use both:
_____ Hours

16b. If YES, please check which combination of hearing protection you use:

Insert plugs & Muffs [ ]
Custom Molded Plugs & Muffs [ ]
Canal Caps & Muffs [ ]
Other _____ [ ]

Subject ID_____

PART III- GENERAL MEDICAL HISTORY

17. Have you ever had, or do you currently have any of the following illnesses/Conditions?

Illness			
Allergies	Yes [ ]	No [ ]	Not Sure [ ]
Arthritis	Yes [ ]	No [ ]	Not Sure [ ]
Kidney disease	Yes [ ]	No [ ]	Not Sure [ ]
Meningitis	Yes [ ]	No [ ]	Not Sure [ ]
Mumps	Yes [ ]	No [ ]	Not Sure [ ]
Diabetes	Yes [ ]	No [ ]	Not Sure [ ]
Autoimmune disease	Yes [ ]	No [ ]	Not Sure [ ]
Meniere's disease	Yes [ ]	No [ ]	Not Sure [ ]
Hypertension	Yes [ ]	No [ ]	Not Sure [ ]
High cholesterol	Yes [ ]	No [ ]	Not Sure [ ]
Cardiovascular disease	Yes [ ]	No [ ]	Not Sure [ ]
Scarlet fever	Yes [ ]	No [ ]	Not Sure [ ]
High fever diseases	Yes [ ]	No [ ]	Not Sure [ ]
Neurological or seizure disorder	Yes [ ]	No [ ]	Not Sure [ ]
Otoschlerosis	Yes [ ]	No [ ]	Not Sure [ ]
White Finger Disease	Yes [ ]	No [ ]	Not Sure [ ]
Other chronic medical problem Please specify_____	Yes [ ]	No [ ]	Not Sure [ ]

18. Medication history:

18a. Please indicate any <u>PRESCRIPTION</u> medications that you are CURRENTLY taking:

Name of Prescription Medication	**For what condition(s) are you taking this medication?**	**How often do you take this?**	**What is your usual dose? *Write DK if you Don't Know.***
		Daily [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ]	
		Daily [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ]	
		Daily [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ]	
		Daily [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ]	
		Daily [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ]	
		Daily [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ]	

Subject ID_____

18b. Please indicate any <u>NON-PRESCRIPTION</u> medications that you are CURRENTLY taking:

Name of NON-Prescription Medication	**For what condition(s) are you taking this medication?**	**How often do you take this?**	**What is your usual dose? *Write DK if you Don't Know.***
		Daily [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ]	
		Daily [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ]	
		Daily [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ]	
		Daily [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ]	
		Daily [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ]	
		Daily [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ]	

18c. Have you ever had any IV (intravenous) Antibiotic treatment? Yes [ ] No [ ] Not Sure [ ]

→ If Yes, did you have this treatment within the last six months? Yes [ ] No [ ]

18d. Have you ever taken any Chemotherapy agents? Yes [ ] No [ ] Not Sure [ ]

→ If NO or NOT SURE, Skip to Question 18e.

→ If YES, which one(s) have you taken?

Cisplatin Yes [ ] No [ ]
Vincristine Yes [ ] No [ ]
Carboplatin Yes [ ] No [ ]
Vinblastine Yes [ ] No [ ]
Bleomycin Yes [ ] No [ ]
Others Yes [ ] No [ ] Please specify_____
[Or write DK for DON'T KNOW]

→ If YES to any of the above, was it taken within the last six months?

Yes [ ] No [ ]

18e. Have you ever taken any Antimalarials (to prevent or treat malaria)?

Yes [ ] No [ ] Not Sure [ ]

→ If NO or NOT SURE, Skip to Question 18f.

→ If YES, which one(s) have you taken?

Quinine Yes [ ] No [ ]
Chloroquine Yes [ ] No [ ]
Other Yes [ ] No [ ] Please specify_____
[Or write DK for DON'T KNOW]

→ If Yes to Quinine or Chloroquine, did you take this within the last 48 hours?

Yes [ ] No [ ]

18f. Have you ever taken any diuretics (used to treat high blood pressure, glaucoma, or edema)?

Yes [ ] No [ ] Not Sure [ ]

→ If NO or NOT SURE, Skip to Question 19.

→ If YES, which one(s) have you taken?

Ethacrynic Acid (Edecrin)	Yes [ ] No [ ]
Furosemide (Lasix)	Yes [ ] No [ ]
Other	Yes [ ] No [ ] Please specify _____

[Or write DK for DON'T KNOW]

→ If YES to Edecrin or Lasix, did you take this within the last week? Yes [ ] No [ ]

19. Have you ever smoked cigarettes? Yes [ ] No [ ]

("No" means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime, or less than one cigarette a day for one year)

→ If NO, Skip to Question 20.

→ If YES, please answer the following:

19a. Do you currently smoke cigarettes (*as of one month ago*)? Yes [ ] No [ ]

19b. How many cigarettes did you smoke per day during the past month?

_____cigarettes/day

19c. How old were you when you first started regular cigarette smoking?

_____yrs

19d. If you have stopped smoking cigarettes completely, how old were you when you stopped?

_____yrs

19e. On the average, of the entire time you smoked, how many cigarettes did you smoke per day?

_____cigarettes/day

20. Have you ever consumed alcoholic beverages on a regular basis (at least 1 beer or 1 glass of wine or 1 mixed drink per week) for at least one year? Yes [ ] No [ ]

→ If YES, average # drinks per week_____

 # years _____

Subject ID_____

21. Have you ever engaged in other recreational drug use? Yes [ ] No [ ]

→ **If NO, Skip to Question 22.**

→ **If YES, please indicate the following:**

a. Type		**b. # Times/Year**	**c. # Years**
Inhalants	Yes [ ] No [ ]		
Amphetamines	Yes [ ] No [ ]		
Cocaine	Yes [ ] No [ ]		
Marijuana	Yes [ ] No [ ]		
Other_____	Yes [ ] No [ ]		

22. Have you ever had problems with the loss of your sense of smell? Yes [ ] No [ ]

PART IV: OCCUPATIONAL/RECREATIONAL HISTORY

23. Have you ever served in the military? Yes [ ] No [ ]

→ **If NO, Skip to Question 24.**

→ **If YES, Please answer the following:**

23a. For how long? _____yrs

23b. During this time, were you exposed to engine or machinery noise? Yes [ ] No [ ]

→ **If YES, how often?**

Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly [ ]

→ **For how long did you have this exposure?** _____yrs _____months

→ **How often did you use hearing protection during these engine or machine exposures?**

Always [ ] Usually[ ] Occasionally [ ] Rarely [ ] Never [ ]

23c. During this time, were you exposed to small arms/artillery fire, or explosive noise?

Yes [ ] No [ ]

→ **If YES, how often?**

Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly [ ]

→ **For how long did you have this exposure**? _____yrs _____months

→ **How often did you use hearing protection during these artillery or explosive noise exposures?**

Always [ ] Usually[ ] Occasionally [ ] Rarely [ ] Never [ ]

Subject ID_____

24. Are you a pilot? Yes [ ] No [ ]

→ If NO, Skip to Question 25.

→ If YES, Please answer the following:

24a. Number of flying hours per year _____

24b. Please list the type of aircraft: _____

24c. How often do you wear hearing protection when flying?

Always [ ] Usually[ ] Occasionally [ ] Rarely [ ] Never [ ]

25. Do you listen to music? Yes [ ] No [ ]

→ If NO, Skip to Question 26.

→ If YES, Please answer the following:

25a. Average number of hours per day _____

25b. How loud do you usually play this music?

Quiet [ ] Moderate [ ] Loud [ ]

25c. What percent of your listening time is with headphones, e.g., with an IPOD? _____%

26. Do you use power tools, chainsaws, or hammers at home? Yes [ ] No [ ]

→ If NO, Skip to Question 27.

→ If YES, Please answer the following:

26a. Average number of hours per week _____

26b. How often do you wear hearing protection when using power tools, chainsaws, or hammers?

Always [ ] Usually[ ] Occasionally [ ] Rarely [ ] Never [ ]

27. For each of the following activities, please indicate whether or not you participate in them, the frequency, and how often you use hearing protection while performing each.

Activity	**If YES, How often?**	**If YES, how often did you use hearing protection?**
Shoot firearms Yes [ ] No [ ]	Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly [ ]	Always [ ] Usually[ ] Occasionally [ ] Rarely [ ] Never [ ]
Ride a motorcycle Yes [ ] No [ ]	Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly [ ]	Always [ ] Usually[ ] Occasionally [ ] Rarely [ ] Never [ ]

Subject ID_____

Ride snowmobiles	Yes [ ] No [ ]	Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly [ ]	Always [ ] Usually[ ] Occasionally [ ] Rarely [ ] Never [ ]
Drive heavy equipment or use loud machinery (trucks, tractors, farm equipment, etc)	Yes [ ] No [ ]	Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly [ ]	Always [ ] Usually[ ] Occasionally [ ] Rarely [ ] Never [ ]
Attend dances, concerts, races, or commercial events?	Yes [ ] No [ ]	Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly [ ]	Always [ ] Usually[ ] Occasionally [ ] Rarely [ ] Never [ ]

28. How many years have you lived in an Urban, Suburban or Rural setting?

Urban *(Population density of at least 1000 people per square mile)* _____ years

Suburban _____ years

Rural _____ years

29. Have you ever been frequently (i.e. several times a week) exposed to oil-based paint or lacquers (other than latex) either on or off the job? (for more than 1 month)?

Yes [ ] No [ ] Not Sure [ ]

→ **If YES, for how long?** _____months_____yrs

30. Have you ever been frequently exposed to solvents (trichloroethylene, carbon tetrachloride, toluene, etc) either on or off the job? (For more than 1 month)

Yes [ ] No [ ] Not Sure [ ]

→ **If YES, for how long?** _____months_____yrs

31. In the table below, please indicate any of the previous occupations that you had PRIOR to working at Alcoa, and indicate the length of time in which you worked in them.

Occupation	**a. Yes/No**	**b. If yes, # Years**
Farmer	Yes [ ] No [ ]	
Insulator	Yes [ ] No [ ]	
Textile Worker	Yes [ ] No [ ]	
Quarry Worker	Yes [ ] No [ ]	
Miner	Yes [ ] No [ ]	
Foundry Work	Yes [ ] No [ ]	
Petrochemical Work	Yes [ ] No [ ]	
Furniture Maker	Yes [ ] No [ ]	
Construction Work	Yes [ ] No [ ]	
Mechanical/Machinist	Yes [ ] No [ ]	
Lumber/ Paper Work	Yes [ ] No [ ]	

Subject ID_____

Shipyard Worker	Yes [ ] No [ ]	
Sandblaster	Yes [ ] No [ ]	
Degreaser	Yes [ ] No [ ]	
Painter	Yes [ ] No [ ]	
Other _____	Yes [ ] No [ ]	
Other _____	Yes [ ] No [ ]	
Other _____	Yes [ ] No [ ]	

32. In the table below, please indicate any occupational exposures that you may have had PRIOR to working at Alcoa:

Exposure			
Beryllium	Yes [ ]	No [ ]	Not Sure [ ]
Welding fumes	Yes [ ]	No [ ]	Not Sure [ ]
Rubber/Plastics (type) _____	Yes [ ]	No [ ]	Not Sure [ ]
Rubber/Plastics (type) _____	Yes [ ]	No [ ]	Not Sure [ ]
Rubber/Plastics (type) _____	Yes [ ]	No [ ]	Not Sure [ ]
Noise	Yes [ ]	No [ ]	Not Sure [ ]
Mercury	Yes [ ]	No [ ]	Not Sure [ ]
Asbestos	Yes [ ]	No [ ]	Not Sure [ ]
Sulfur Dioxide	Yes [ ]	No [ ]	Not Sure [ ]
Radiation	Yes [ ]	No [ ]	Not Sure [ ]
Lead	Yes [ ]	No [ ]	Not Sure [ ]
Caustics (e.g. acids/bases)	Yes [ ]	No [ ]	Not Sure [ ]
Silica	Yes [ ]	No [ ]	Not Sure [ ]
Chlorine gases	Yes [ ]	No [ ]	Not Sure [ ]
Repeated physical trauma	Yes [ ]	No [ ]	Not Sure [ ]
Arsenic	Yes [ ]	No [ ]	Not Sure [ ]
Talc	Yes [ ]	No [ ]	Not Sure [ ]
Other Irritant Gases/Fumes	Yes [ ]	No [ ]	Not Sure [ ]
Fluoride	Yes [ ]	No [ ]	Not Sure [ ]
Benzene	Yes [ ]	No [ ]	Not Sure [ ]
Pesticides or Related Chemicals	Yes [ ]	No [ ]	Not Sure [ ]
Other Metals	Yes [ ]	No [ ]	Not Sure [ ]
Other oils or machining fluid	Yes [ ]	No [ ]	Not Sure [ ]
Other Dust	Yes [ ]	No [ ]	Not Sure [ ]
Other Solvents	Yes [ ]	No [ ]	Not Sure [ ]
Other mad-made fibers (e.g. wool)	Yes [ ]	No [ ]	Not Sure [ ]

Subject ID_____

33. Do you currently participate in any of the following hobbies? If YES, please indicate frequency.

Hobby	**a. Yes/No**	**b. If Yes, Frequency**
Stained glass work	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly
House Painting	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly
Melting Metal	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly
Model plane or car building	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly
Jewelry Making	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly
Paint Removal	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly
Silk Screening	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly
Furniture Refinishing	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly
Pottery/Ceramics (with lead glazes)	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly
Fishing/Making lead sinkers	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly
Auto Refinishing	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly
Wood Working	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly
Gardening with Pesticides	Yes [ ] No [ ]	[ ] Daily [ ] Several times weekly [ ] Several times monthly [ ] Less than monthly