APPENDIX AVAILABLE ON REQUEST

Research Report 162

Assessing the Impact of a Wood Stove Replacement Program on Air Quality and Children's Health

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Appendix E. Survey

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APPENDIX E. SURVEY

In this survey "your child" refers to the child who brought the questionnaire home from school. If you have more than one child attending Asa Wood or Libby Middle, please answer on separate forms provided by each child. Please answer the questions by checking a box or writing in the spaces provided.

PART 1

What grade is your child in? (check one)

ungraded / special education	4th grade	9th grade
kindergarten	5th grade	10th grade
1st grade	6th grade	
2nd grade	7th grade	
3rd grade	8th grade	

Is your child a boy or a girl?

Boy Girl

Does anyone in your household smoke tobacco products (for example: cigarettes, cigars, pipe tobacco)?

Yes No

What type of home heating is used? Please check the correct answer. If more than one heating source is used, please check all that apply and indicate which one is used as the main heating source.

	Used in Home?		Main Source of Heating?	
	Yes	No	Yes	No
Fireplace?				
Wood stove?				
Pellet stove?				
Propane?				
Gas Furnace?				
Oil or kerosene?				
Electric baseboard heating?				

Who completed this survey?

Mother Father Other (specify):_____

PLEASE CONTINUE ON THE NEXT PAGE

PART 2

For the following questions, please indicate if your child experienced any of the following **in the past 2 months**:	**[PLEASE CIRCLE ANSWERS]**		
Has your child had wheezing or whistling in the chest?	Yes	No	Don't Know
Has your child woken up with a feeling of tightness in the chest first thing in the morning?	Yes	No	Don't Know
Has your child had an *attack* of shortness of breath that came on during the day while they were not doing anything strenuous?	Yes	No	Don't Know
Has your child had an *attack* of shortness of breath that came on after they stopped exercising?	Yes	No	Don't Know
Has your child been woken at night by an attack of shortness of breath?	Yes	No	Don't Know
Has your child been woken at night by an attack of coughing?	Yes	No	Don't Know
Has your child been woken at night by an attack of wheezing or whistling in the chest?	Yes	No	Don't Know
Has wheezing or whistling in the chest ever been severe enough to limit your child's speech to only one or two words at a time between breaths?	Yes	No	Don't Know
How many attacks of wheezing has your child had in the last 2 months?	None	1 – 3	4 – 12
In the last 2 months, how often, on average, has your child's sleep been disturbed due to wheezing?	Never	Less than one night per week	One or more nights per week

In the last 2 months, what has made your child's wheezing or whistling in the chest, coughing, or shortness of breath worse? **[Check all that apply]**

Weather
Pollen
Dust
Pets
Food or Drinks
Soaps, sprays or detergents
Emotion
Fumes
Wool clothing
Colds or Flu
Cigarette smoke
Other (please list): _____

PLEASE CONTINUE ON THE NEXT PAGE

Has your child ever had asthma?	Yes	No

[If No, skip to 18]

Was your child's asthma *diagnosed by a doctor*?	Yes	No
About what age did your child's asthma *start*?	_____ years old	
Has your child had an attack of asthma at any time in the *last 12 months*?	Yes	No
Is your child currently taking any medicines for asthma (including inhalers, aerosols or tablets)?	Yes	No
Does your child use the inhaler or nebulizer more or less on weekdays?	More on weekdays	Less on weekdays
Has your child ever had hay fever?	Yes	No

[If No, skip to 20]

Does your child currently take any medicines for hay fever (including antihistamines, nasal sprays, or inhalers)?	Yes	No

Has your child experienced any of the symptoms listed below **in the past 2 months?**			
Watery, itchy, or irritated eyes	Yes	No	Don't Know
Wheezing	Yes	No	Don't Know
Headache	Yes	No	Don't Know
Sore throat	Yes	No	Don't Know
Pain when swallowing food or drink	Yes	No	Don't Know
Unusual tiredness, fatigue, or drowsiness	Yes	No	Don't Know
Fever over 102 degrees	Yes	No	Don't Know
Stuffy or runny nose, or sinus congestion	Yes	No	Don't Know
Coughing	Yes	No	Don't Know
Sneezing	Yes	No	Don't Know
Dizziness or lightheadedness	Yes	No	Don't Know
Nausea	Yes	No	Don't Know
Vomiting	Yes	No	Don't Know
Stomach pain	Yes	No	Don't Know
Diarrhea	Yes	No	Don't Know

PLEASE CONTINUE ON THE NEXT PAGE

PART 3.

<u>In the last 2 months</u> has your child had any of the following conditions? Please check the appropriate boxes that apply. Also, please indicate the number of times and whether or not a doctor diagnosed the illness.

	Has you child had this condition in the last 2 months?		**Number of times in the last 2 months**	**Did a doctor diagnose this?**	
Flu?	Yes	No		Yes	No
Cold?	Yes	No		Yes	No
Throat infection?	Yes	No		Yes	No
Middle-ear infection?	Yes	No		Yes	No
Bronchitis?	Yes	No		Yes	No
Pneumonia?	Yes	No		Yes	No

THANK YOU FOR COMPLETING THIS SURVEY. PLEASE ENCLOSE THE COMPLETED SURVEY IN THE ENVELOPE PROVIDED. SEAL THE ENVELOPE AND HAVE YOUR STUDENT RETURN THE ENVELOPE TO HIS/HER HOMEROOM TEACHER.