Telephone Introduction for Patient Interviews

LEAD POISONING

1. Hello, my name is ___________________. I’m calling for Mr./Ms./Mrs. _____________. Is he/she in?
   
   (NO) I’m calling on behalf of the State of Michigan. When do you expect him/her home? Please tell him/her I called. My toll-free telephone number is 1-800-446-7805.

   (YES) I’m calling on behalf of the State of Michigan. We receive reports of all blood lead levels, and we have recently received your blood lead report. Recently we sent you a letter asking for your help in our special investigation into determining the cause of elevated blood lead levels.

2. Do you remember receiving the letter?
   
   (YES) Good. I’d like to take a moment to describe what you can do to help. GO TO PART 3.

   (NO) Let me see...I see that we mailed the letter to you on (date) to (address). Is that your correct address? If not, I will send you another copy of the letter. While I have you on the phone, let me explain briefly what the letter is about. GO TO PART 3.

3. We are making follow up telephone calls to people who have had their blood lead level checked. We received a report of your blood lead level of ___ ug/dL taken on (date).

   Your participation in this investigation is completely voluntary. If you decide to participate, I will go through a questionnaire by phone. This takes approximately 15 minutes, and would complete your participation in this investigation. You indicate your voluntary participation by answering the questions. You can end your participation or refuse to answer individual questions at any time. All information you give us will be kept strictly confidential. We do not share this information with your employer. The State of Michigan will use this information to understand more about lead exposures and what can be done to reduce exposure to lead. If your exposure to lead occurred from work and you are still working at the location where you were exposed, you may benefit if the results of this investigation lead to changes in your workplace.

4. Will you help us by participating in this questionnaire?
   
   (YES) If this is a good time to do the questionnaire, I will begin with the questions now. (If this is not a good time, arrange a day and time to call back.)

   (NO) I see. May I ask what your concerns are?
Please complete the following questionnaire to the best of your knowledge. If you have any questions or if you wish to complete the questionnaire over the telephone, please call Dr. Kenneth Rosenman or his staff at their toll-free telephone number: 1-800-446-7805.

### 1. What is your full name?

____________________________
First

____________________________
Last

### 2. What is your address?

_________________________________________________________________
City State Zip

### 3. What is your home telephone number?

( ) ____________ - ______________

### 4. What is your social security number? 

(If refusal to answer, try to obtain the last 4-digits)

### 5. What is your gender?

5. Male 1 Female 2

### 6. What is your date of birth?

(Confirm DOB if available in chart.)

### 7. Are you of Hispanic origin?

7. No 1 Yes 2 DK 3

### 8. How would you be classified? The choices are:

8. White 1
African American 2
Asian/Pacific Islander 3
Native American/Alaskan 4
Other 5
Unknown 9

### 9. What is the highest level of education you have completed?

9. 7th grade or less 1
8th, 9th, 10th, or 11th grade 2
High School Graduate 3
1-3 years College/Tech 4
4+ years College/Tech 5
Unknown 9
Why did your doctor have your blood tested for Lead?

(IF THIS IS A FLINT RESIDENT AND POSSIBILITY OF EXPOSURE FROM DRINKING WATER, ASK SUPPLEMENTAL WATER QUESTIONNAIRE NOW)

How were/are you exposed to Lead?

12. Within the past 3 months, have you lost more than 10 lbs. without dieting? 12. No 1 Yes 2 DK 3
13. Within the past 3 months, have you had continued loss of appetite? 13. No 1 Yes 2 DK 3
14. Within the past 3 months, have you had pains in your belly? 14. No 1 Yes 2 DK 3
   If YES:
   a. Does the pain come before meals? 14a. No 1 Yes 2 DK 3
   b. Does the pain come after meals? 14b. No 1 Yes 2 DK 3
   c. Does the pain come with constipation? 14c. No 1 Yes 2 DK 3
15. Within the past 3 months, have you had frequent pain or soreness in your joints? 15. No 1 Yes 2 DK 3
16. Within the past 3 months, have you noticed muscle weakness? 16. No 1 Yes 2 DK 3
17. Within the past 3 months, have you been bothered by:
   a. Headaches?
      1) If YES, how often? 17a. No 1 Yes 2 DK 3
      17a-1. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9
   b. Dizziness?
      1) If YES, how often? 17b. No 1 Yes 2 DK 3
      17b-1. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9
   c. Feeling sad or depressed?
      1) If YES, how often? 17c. No 1 Yes 2 DK 3
      17c-1. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9
   d. Being tired?
      1) If YES, how often? 17d. No 1 Yes 2 DK 3
      17d-1. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9
   e. Feeling nervous?
      1) If YES, how often? 17e. No 1 Yes 2 DK 3
      17e-1. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9
   f. Waking up at night?
      1) If YES, how often? 17f. No 1 Yes 2 DK 3
      17f-1. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9
   g. Nightmares or strange dreams?
      1) If YES, how often? 17g. No 1 Yes 2 DK 3
      17g-1. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9
   h. Being irritable?
      1) If YES, how often? 17h. No 1 Yes 2 DK 3
      17h-1. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9
   i. Being unable to concentrate?
      1) If YES, how often? 17i. No 1 Yes 2 DK 3
      17i-1. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9
18. Have you, or your spouse, had trouble having a child? 18. No 1 Yes 2 DK 3
   a. If YES, have you been told you had a decreased sperm count? (If female, then NA)
      18a. No 1 Yes 2 DK 3 N (women) 4
19. Within the past 3 months, have you been told by a doctor your red blood cell count was reduced?  
   19. No 1 Yes 2 DK 3

20. Has a doctor told you that you have kidney disease?  
   a. If YES, what year were you told you had it?  
      20a. ___ ___ ___ ___ CCYY

21. Do you have high blood pressure?  
   If YES:  
   a. What year were you told you first had it?  
      21a. ___ ___ ___ ___ CCYY
   b. What is your blood pressure?  
      21b. ___ ___ / ___ ___ ___
   c. Do you take medication for your blood pressure?  
      21c. No 1 Yes 2 DK 3

54. Has a health care provider told you, you have hearing loss?  
   If YES:  
   a. What year were you told you had it?  
      54a. ___ ___ ___ ___ CCYY
   b. Were you exposed to loud noise on a regular basis (had to raise voice to be heard)?  
      54b. No 1 Yes 2 DK 3
   b-1. If Q54b YES, for how many years?  
      54b-1. ___ ___ total years

22. Now I’m going to read you a list of activities people sometimes do and for each activity please tell me whether you have, or anyone in your household has, done this activity during the past 12 months. (Answer YES, only if non-work activities)  

   NOTE: In questions 22a to 22j first part relates to Patient, second part relates to Other HH Member(s) if Patient=No.

<table>
<thead>
<tr>
<th>SELF</th>
<th>OTHER HH MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Remodeling or Renovating (not at work)?</td>
<td>22a. No 1 Yes 2 DK 3</td>
</tr>
</tbody>
</table>
| If YES:  
   1) In what year was the building you worked on built? | 22a-1. ___ ___ ___ ___ CCYY |
| 2) How many years have you been doing this? | 22a-2. |
| 3) In the last year, how often have you done this? | 22a-3. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9 |
| b. Painting (not at work)? | 22b. No 1 Yes 2 DK 3 | No 1 Yes 2 DK 3 |
| If YES:  
   1) In what year was the building you painted built? | 22b-1. ___ ___ ___ ___ CCYY |
| 2) How many years have you been doing this? | 22b-2. |
| 3) In the last year, how often have you done this? | 22b-3. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9 |
| c. Making pottery/ceramics using glazes? | 22c. No 1 Yes 2 DK 3 | No 1 Yes 2 DK 3 |
| If YES:  
   1) How many years have you been doing this? | 22c-1. |
| 2) In the last year, how often have you done this? | 22c-2. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9 |
| d. Firearms target practice? | 22d. No 1 Yes 2 DK 3 | No 1 Yes 2 DK 3 |
| If YES:  
   1) Name and Location of range: | |
| 2) Is the range Indoor or Outdoor or Both? | 22d-2. Indoor 1 Outdoor 2 Both 4 DK 3 |
| 3) How many years have you been doing this? | 22d-3. |
| 4) In the last year, how often have you done this? | 22d-4. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9 |
| e. Making stained glass? | 22e. No 1 Yes 2 DK 3 | No 1 Yes 2 DK 3 |
| If YES:  
   1) How many years have you been doing this? | 22e-1. |
<p>| 2) In the last year, how often have you done this? | 22e-2. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9 |</p>
<table>
<thead>
<tr>
<th>22f. Making fish weights / sinkers?</th>
<th>SELF</th>
<th>OTHER HH MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>If YES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22f-1.</td>
<td>No 1 Yes 2 DK 3</td>
</tr>
<tr>
<td>1) How many years have you been doing this?</td>
<td>22f-2.</td>
<td>Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9</td>
</tr>
<tr>
<td>2) In the last year, how often have you done this?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>22g. Reloading or casting bullets, shot, or other objects?</th>
<th>SELF</th>
<th>OTHER HH MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>If YES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22g-1.</td>
<td>No 1 Yes 2 DK 3</td>
</tr>
<tr>
<td>1) How many years have you been doing this?</td>
<td>22g-2.</td>
<td>Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9</td>
</tr>
<tr>
<td>2) In the last year, how often have you done this?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>22h. Soldering, brazing or tinning?</th>
<th>SELF</th>
<th>OTHER HH MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>If YES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22h-1.</td>
<td>No 1 Yes 2 DK 3</td>
</tr>
<tr>
<td>1) How many years have you been doing this?</td>
<td>22h-2.</td>
<td>Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9</td>
</tr>
<tr>
<td>2) In the last year, how often have you done this?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>22i. Auto body work?</th>
<th>SELF</th>
<th>OTHER HH MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>If YES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) How many years have you been doing this?</td>
<td>22i-1.</td>
<td>No 1 Yes 2 DK 3</td>
</tr>
<tr>
<td>2) In the last year, how often have you done this?</td>
<td>22i-2.</td>
<td>Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>22j. Using pigments / pastels?</th>
<th>SELF</th>
<th>OTHER HH MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>If YES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) How many years have you been doing this?</td>
<td>22j-1.</td>
<td>No 1 Yes 2 DK 3</td>
</tr>
<tr>
<td>2) In the last year, how often have you done this?</td>
<td>22j-2.</td>
<td>Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9</td>
</tr>
</tbody>
</table>

23. Do you use any of the following:

Ask everyone:

<table>
<thead>
<tr>
<th>23a. Imported or handmade ceramics for cooking or serving food/drink?</th>
<th>SELF</th>
<th>OTHER HH MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>No 1 Yes 2 DK 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>23b. Cosmetics from India or Asia, such as “Kohl”, (“Alkohl”), “Surma” or “Ceruse”?</th>
<th>SELF</th>
<th>OTHER HH MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>No 1 Yes 2 DK 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>23c. Medications such as:</th>
<th>SELF</th>
<th>OTHER HH MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>23c-1. Only ask if HISPANIC Community:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azarcon, Greta, Liga, Maria Luisa, Alarcon, Coral, Rueda, or “empacho”</td>
<td>23c-2.</td>
<td>No 1 Yes 2 DK 3</td>
</tr>
<tr>
<td>23c-2. Only ask if SE ASIAN Community: Pay-loo-ah</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23c-3. Only ask if INDIAN (ASIAN) Community: Ayurvedic, Bala Goli, Ghasard, Kandu</td>
<td>23c-3.</td>
<td>No 1 Yes 2 DK 3</td>
</tr>
</tbody>
</table>

24. Do you know if anyone in your household works in a job that may expose them to Lead?

If YES, what person and job is this?

25. Have you ever been given medication to lower your Blood Lead Level?

If YES:

<table>
<thead>
<tr>
<th>25b. What month and year did you take (name of medication)?</th>
<th>SELF</th>
<th>OTHER HH MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>M M  C C  Y Y</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
26. Was your blood test of ________ ug/dL on (date of test) part of a company medical screening?  

If YES:

a. Are you notified of your Blood Lead results?  

b. If Q26a YES, are you given the results in writing?  

c. Did a doctor or nurse, employed by your company, examine you because of your Blood Lead results?  

Please tell us the name of the company doctor, nurse or mobile service that drew your blood sample:

________________________________________________________________________

If NO or DK if testing was part of a company medical screening:

d. Did you go to your own doctor for the blood test?  

Please tell us the name and location of the doctor that drew your blood sample:

________________________________________________________________________

________________________________________________________________________

27. INTERVIEWER:
Make determination from reviewing previous questions, is source of Lead exposure work-related?  

If any chance work-related, then continue with Q28.  

If YES or DK, continue with Q28.  

If NO, go to Q43, page 7.

28. a. What is the Name and Address of the company you were working at when your blood was tested for Lead?

________________________________________________________________________

City         State
________________________________________________________________________

b. What does this company do or manufacture?

________________________________________________________________________

28b. ___ ___ ___ ___ SIC

________________________________________________________________________

c. What job did you have when the blood test was taken?

________________________________________________________________________

28c. ___ ___ ___ COC
29. Which department, building, section (or job site) is this in?
INTERVIEWER: very important, try to get detail.

30. On this job, how many people also work(ed) as (occupation)?
   number of people

31. How many people work(ed) in the same area as you, not necessarily doing the same job?
   number of people

32. Can you tell me more about what you do/did as a (occupation), what materials you use, what you are making, the area you work in, and what you do on your job?
INTERVIEWER: very important, try to get detail.

Materials: 

Worksite description: 

Work process: 

33. a. What month and year did you begin working for (employer name where Lead exposure occurred, see Q28a)?
   M M / C C Y Y

   b. What month and year did you start as (occupation where Lead exposure occurred, see Q28c)?
   M M / C C Y Y

34. Is there a separate place for you to keep your dirty work clothes and clean street clothes? 
   No 1   Yes 2   DK 3

35. Where are you work clothes washed?
   At Work 1   At Home 2   Laundry Mat 4   DK 3

36. At work, is there a place you can shower before getting into your clean street clothes?
   No 1   Yes 2   DK 3

37. Is there a lunch room at work?
   No 1   Yes 2   DK 3

38. At work, do you clean off the dust from your clothes and wash your hands before eating?
   No 1   Yes 2   DK 3

39. At work, do you eat in a lunchroom? (If Q37=No, or if response “off premises” / “out”, then NA)
   No 1   Yes 2   DK 3   NA 4

40. At work, do you wear a respirator?
   No 1   Yes 2   DK 3

   If YES:
   a. How many hours do you wear the respirator?
   40a. ___ ___ hours per day

   b. Where do you keep your respirator when you are not wearing it?

41. Are you exposed to Lead at work now?
   No 1   Yes 2   DK 3

42. Have you ever been removed from a job before because of a high Lead level?
   No 1   Yes 2   DK 3

   a. If YES, what is the most recent year you were removed?
   42a. ___ ___ ___ ___ CCYY
43d. Are you currently taking Ayurvedic herbal medication? 43d. No 1 Yes 2 DK 3

43. Are you currently taking any type of medication (including: Rx, OTC, vitamins, herbal, etc.)? 43. No 1 Yes 2 DK 3
   a. If YES, what kind of medication are you taking?
   b. If YES, how often are you taking (medication)?
   c. If YES, how long have you been taking (medication)?

44. Have you previously worked at a job where you were exposed to Lead? 44. No 1 Yes 2 DK 3
   a. If YES, list company name, job and years:
      44a. ___ ___ total number years

45. Have you ever smoked cigarettes? (No means less than 5 packs of cigarettes or 12 oz. of tobacco in a lifetime.) 45. No 1 Yes 2 DK 3
   a. If YES, do you now smoke cigarettes? 45a. No 1 Yes 2 DK 3
      If Q45a YES:
      b. Do you smoke in your work area? 45b. No 1 Yes 2 DK 3
      c. Do you keep your cigarettes in your pocket while at work? 45c. No 1 Yes 2 DK 3

46. Do you drink beer, wine or hard liquor? 46. No 1 Yes 2 DK 3
   If YES:
   a. On the average, how often? 46a. Daily 1 Weekly 2 Monthly 3 Seldom 4 DK 9
   b. When you do drink, how much? 46b. ___ ___ glasses/shots/bottles/cans (circle one)
   c. Do you drink homemade liquor? Y N DK 46c. ___ ___ glasses/shots/bottles/ (circle one)

55. Have you ever had a gun shot (bullet) wound? 55. No 1 Yes 2 DK 3
   a. If YES: Do you still have any fragments in you? 55a. No 1 Yes 2 DK 3
      b. If YES to fragments: What part of your body?

47. Are there children, 6 years or under, living or regularly spending time in your house? 47. No 1 Yes 2 DK 3
   e. If YES, can you please tell me the names and ages of the children, 6 years or under, living or regularly spending time in your house?
      __________________________________________
      __________________________________________
   a. If Q47 YES, have any of these children been tested for Lead? 47a. No 1 Yes 2 DK 3
   b. If Q47a YES, how many children 6 years or under were tested? 47b. ___ ___ number of children
   c. If Q47a YES, have any of these children had elevated Lead levels? 47c. No 1 Yes 2 DK 3
      c.1. If YES, what were the blood lead levels? 47c.1. ___ child 1, ___ child 2
      ___ child 3, ___ child 4
   d. If Q47c YES, how many of these children had elevated Lead levels? 47d. ___ ___ number of children
The Michigan Department of Licensing and Regulatory Affairs has the legal responsibility to inspect your workplace. Would you be concerned if they inspected your workplace even though your name would be kept completely confidential?

NO  ____  YES  ____  N/A  ____

If YES, what exactly are your concerns?

____________________________________________________________________

____________________________________________________________________

If you have concerns, what can we do to minimize your concerns?

____________________________________________________________________

____________________________________________________________________

What is the DEPARTMENT and BUILDING or ADDRESS where you were working?

____________________________________________________________________

____________________________________________________________________

Please describe how we would find the actual LOCATION where you were exposed to lead:

____________________________________________________________________

____________________________________________________________________

---

OFFICE USE ONLY

48. Highest Lead level:  ____  ____  ____ ug/dL

49. Date of highest Lead level:  ____  ____  ____  ____  ____  ____ MM-DD-CCYY

50. County of residence  ____  ____  ____ (use State coding scheme)

51. County of work:  ____  ____  ____ (use State coding scheme)

52. Work-Related  ____  ____  ____

53. Employer ID Number  ____  ____  ____  ____  ____