



Questionnaire for Environmental Exposures, Toxins, & Neurological Disease

The information collected in this questionnaire is being used in a **research** project led by Dr. Elijah Stommel from the Department of Neurology at Dartmouth-Hitchcock Medical Center, with site affiliations at the Cleveland Clinic, University of Vermont Medical Center, and Johns Hopkins Hospital. The purpose of this research is to identify lifetime exposure factors that affect neurological health.

Your participation in this research is important and **voluntary**. Participation involves providing the information requested in this questionnaire, which may take about an hour. You may choose to not answer some of the questions. If the researchers have any questions for you, they may wish to contact you.

Please indicate whether you agree to be contacted by the researchers in the future.

Yes, I agree to be contacted in the future:

Name _____ Phone (____) _____ - _____

E-mail _____@_____.com

No, I prefer not to be contacted in the future.

The information collected for this research will be held confidentially and the researcher will protect your identity by controlling access to the research data. Neither your name nor any other identifying information about you will be used in any presentation or article written about this research. Questions about this research study should be directed to the Project Assistant at the following number or email address:

Toll-free number: 1-866-894-8131

E-mail address: neuroresearch@hitchcock.org

Where did you hear about this study and receive this questionnaire?

University of Vermont Medical Center (UVM)

Dartmouth-Hitchcock Medical Center

Cleveland Clinic Foundation

Johns Hopkins Medicine

Received Questionnaire by Mail

Other _____

Today's Date: ___ ___ / ___ ___ / ___ ___

Who is filling out this form? Participant Family Member Caregiver

If you are a family member or caregiver, please fill out this questionnaire as if you were the patient/participant.

Participant's Age: _____ Participant's Gender: Male Female

Height 6 months ago: ___' ___", Weight 6 months ago _____ lbs.

Height at Age 25: ___' ___", Weight at Age 25: _____ lbs.

Where were you born?

_____ Town

_____ State/Province

_____ Country

What was your marital status as of 6 months ago?

Never married

Married

Separated

Divorced

Widowed

Living with partner

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Personal and Family History

1. Do you have any of the following illnesses [*amyotrophic lateral sclerosis (ALS), Parkinson's diseases (PD), Alzheimer's Disease (AD)*]? Yes No

	ALS	PD	AD	Dementia	Other Neurological Disorder (please specify in box)
You (please check all that apply)					

ALS Diagnosis Date: __ __/__ __/__ __

PD Diagnosis Date: __ __/__ __/__ __

AD Diagnosis Date: __ __/__ __/__ __

Dementia Diagnosis Date: __ __/__ __/__ __

Other Neurological Disorder Diagnosis Date: __ __/__ __/__ __

2. Has anyone in your immediate family been diagnosed with ALS, PD, AD, or Dementia?

(Check all that apply:)

	ALS	PD	AD	Dementia	Other Neurological Disorder (please specify in box)
Immediate Family Members					
Mother					
Father					
Brother/Sister					
Child					
Extended Family					
Spouse					
Maternal Grandparent					
Paternal Grandparent					
Maternal Aunt/Uncle					
Paternal Aunt/Uncle					

If you have ALS, what was the site of onset? (Please check all that apply.)

Bulbar Left Arm Right Arm Left Leg Right Leg Not Applicable

Other _____

If you have Parkinson's, what was the site of onset? (Please check all that apply.)

Bulbar Left Arm Right Arm Left Leg Right Leg Not Applicable

Other _____

3. Do you have any other illnesses? Yes No If yes, what are they? _____

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4. Residential Calendar

Directions: The calendar on the following pages is intended to help you remember where you have lived. Write the address, town, state, & zip code next to the year you started to live in each place, beginning with your birthplace. If you lived in more than 1 place in any year, write the place where you lived the longest that year. DESCRIBE GPS/LAT/LONG

Age	Year	Street Address (not PO Box)	Town	State	Zip Code
50	2012	7 Lebanon Street	Lebanon	NH	03766
51		↓			
52					
53	2015				

Draw vertical lines to span the years lived in each place.

Indicate the primary drinking water source of each home to the best of your ability: public/city well, public/city surface water, private well, private surface water, or purchased bottled/filtered water.

AGE	YEAR	STREET ADDRESS <i>(not PO Box)</i> or GPS Code <i>(Latitude and Longitude)</i>	TOWN	STATE	ZIP	DRINKING WATER SOURCE
Born						
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
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25						
26						

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AGE	YEAR	STREET ADDRESS <i>(not PO Box)</i>	TOWN	STATE	ZIP	DRINKING WATER SOURCE
27						
28						
29						
30						
31						
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AGE	YEAR	STREET ADDRESS <i>(not PO Box)</i>	TOWN	STATE	ZIP	DRINKING WATER SOURCE
64						
65						
66						
67						
68						
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84						
85						

5. Prior to 6 months ago, had you ever lived in a home located on or near (within a 2 mile distance) a lake, river, pond, estuary, ocean, or waterbody?

Yes, full-time residence Yes, part-time residence No

6. Have there ever been blue-green algae “blooms” or green surface scum on the water body’s surface?

Yes No

If yes, which waterbodies (most recent to least recent)?

			(___ / _____ - ___ / _____)
<i>Waterbody Name</i>	<i>Town</i>	<i>State</i>	<i>Months/Years of Observed Bloom</i>
			(___ / _____ - ___ / _____)
<i>Waterbody Name</i>	<i>Town</i>	<i>State</i>	<i>Months/Years of Observed Bloom</i>
			(___ / _____ - ___ / _____)
<i>Waterbody Name</i>	<i>Town</i>	<i>State</i>	<i>Months/Years of Observed Bloom</i>

7. Has the lake or waterbody ever been closed for recreation due to pollution or algae “blooms”?

Yes No If yes, which lake? _____

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Water Usage

8. Do you use or have you used water from a lake or river for drinking?

Yes No If yes, which lake/river? _____

9. Do you use or have you used water from a lake or river for household chores

(showering, bathing, washing dishes?)

Yes No If yes, which lake/river? _____

Medications/Supplements

10. Have you ever been treated for more than 6 weeks with a drug that suppresses your immune system?

(Examples: corticosteroids, methotrexate, infliximab, rituximab, entanercept, hydroxychloroquine, sulfasalazine, and other medications used in the treatment of autoimmune, joint, & skin disorders such as rheumatoid arthritis or psoriasis)

Yes No If yes, which medications?

1. _____ for which calendar years? _____

2. _____ for which calendar years? _____

3. _____ for which calendar years? _____

11. Have you ever taken supplements containing "Spirulina" or blue-green algae?

Yes No If yes, for which calendar years? _____

12. Have you ever undergone chemotherapy for the treatment of cancer? (Examples: Bendamustine Hydrochloride, Azacitidine, Vismodegib, Palonosetron Hydrochloride and Netupitant, Mesna, Letrozole)

Yes No If yes, where did the cancer originate on your body? _____

For what years did you receive chemotherapy? _____

What medications did you take? _____

Physical Trauma and Personal History

13. **Military Background:** Have you ever served in the military?

Yes No If yes, for which years? _____ - _____

Which branch/division? _____

What were your primary activities? _____

In which war were you deployed (respond N/A if not deployed)? _____

Were you deployed outside of the USA?

Yes No If yes, where (town/country) and for which years?

_____ (_____ - _____)

_____ (_____ - _____)

_____ (_____ - _____)

14. **Athletics:** Prior to 6 months ago, did you ever participate regularly in strenuous athletic activities, such as running, swimming, or other competitive sports (soccer, football, etc.)?

Yes No If yes, how many years? _____ For how many hours/week? _____

15. Have you ever suffered head trauma or a concussion that caused you to black out or lose consciousness?

Yes No

If yes, at which age group (Select all that apply)? 0-15 16-30 31-45 46-60 61+

How many injuries? 1-2 3-4 5-10 11-15 15+

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16. Have you ever suffered a severe electrical burn or been electrocuted?

Yes No

If **yes**, at which age group (*Select all that apply*)? 0-15 16-30 31-45 46-60 61+

How many times? 1-2 3-4 5-10 11-15 15+

17. **Tobacco use:** Have you ever smoked more than 100 cigarettes/cigars (in your whole life)?

Never Smoked Yes, I am a current smoker Yes, but I have quit

If **yes**, at what age did you start? _____

At what age did you quit? _____

As of 6 months ago were you smoking? No, not at all Yes, some days Yes, every day

On average, for the entire time that you smoked before 6 months ago, how many cigarettes/ cigars did you smoke per day? (1 pack=20 cigarettes) _____

18. **Occupation:** Please describe all prior jobs held for 6 or more months, the approximate number of years that you held that occupation(s), and the town or city where you worked.

Occupation	Calendar Years	City, State, Zip Code	Full or Part-time
	to		<input type="checkbox"/> Full <input type="checkbox"/> Part-time
	to		<input type="checkbox"/> Full <input type="checkbox"/> Part-time
	to		<input type="checkbox"/> Full <input type="checkbox"/> Part-time
	to		<input type="checkbox"/> Full <input type="checkbox"/> Part-time
	to		<input type="checkbox"/> Full <input type="checkbox"/> Part-time

19. Did your job(s) or hobbies involve exposure to potentially harmful chemicals?

Yes No

If **yes**, please fill in how often (weeks/month, months/year) and for which calendar years you were exposed.

Exposure	Hours per Month	Months per Year	Calendar Years
Lead			to
Mercury			to
Solvents (<i>paint thinners, degreasers, methanol</i>)			to
Cooling, cutting, lubricating oils			to
Pesticides			to
Insecticides			to
Other:			to

20. Have you ever had a blood or urine test for heavy metals such as lead?

Yes No

If **yes**, please describe any positive tests: _____

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21. **Hobbies & Other Activities:** Did you ever participate in the following activities for at least 2 times each month for a year or longer? (If yes, please indicate the frequency and duration of each activity.)

Hobby or Other Activity	Hours/Month	Months/Year	Calendar Years
Creating or Fixing Objects			
Repairing or restoring cars			to
Soldering, Brazing, or Tinning			to
Carpentry			to
Home remodeling/renovating			to
Electrical work			to
Use of paint strippers or thinners			to
Casting bullets or other lead objects			to
Making or using lead fish weights/sinkers			to
Metal work			to
Mercury amalgamation (dentistry)			to
Outdoor Activities			
Animal husbandry			to
Farming/Agriculture			to
Hunting or shooting, either animals, skeet, trap or targets			to
Gardening or lawn care			to
Burning trash			to
Art			
Oil painting (fine art)			to
Using pastels/pigments			to
Make silver jewelry			to
Polished or ground gemstones using lead			to
Done enameling			to
Glass blowing			to
Make stained glass or art glass using lead joints			to
Pottery/Ceramics			to
Water Activities			
Swimming in lakes or rivers			to
Boating, sailing, or kayaking			to
Water skiing			to
Wind surfing			to

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Demographics

22. What was your family yearly income before taxes 6 months ago? Please include all personal income, income from your spouse and income from other members of your household. Which range corresponds to your family income range?

- Less than \$9,999
 \$10,000-\$19,999
 \$20,000-\$29,999
 \$30,000-\$39,999
 \$40,000-\$49,999
 \$50,000-\$59,999
 \$60,000-\$79,999
 \$80,000-\$149,999
 \$150,000+
 I Do Not Know

23. How many years of schooling have you completed prior to 6 months ago? _____

24. What is the highest degree that you have attained prior to 6 months ago?

- Grade school (grades 1-8)
 High School diploma
 Technical or trade school diploma
 College diploma
 Graduate school diploma
 Other: _____

What do you consider to be your race or ethnic group? *Please check all that apply.*

- White
 Black, African American
 Asian Indian
 Chinese
 Filipino
 Japanese
 Korean
 Vietnamese
 Puerto Rican
 Cuban
 Native Hawaiian
 Guamanian or Chamorro
 Samoan
 American Indian or Alaskan (Specify name of enrolled or principal tribe _____)
 Other Asian (specify race _____)
 Other Pacific Islander (specify race _____)
 Other Spanish/Hispanic/Latino (specify race _____)

Dietary Consumption of Fish and Shellfish (Questions 25-28) *Please answer the following questions in regards to your dietary habits over the past 10 years.*

25. Prior to the 6 months ago, did you eat seafood (fish or shellfish) more than 15 times per year? Yes No

26. Have you **caught** freshwater or marine fish for food? Yes No

27. Have you eaten the fish, shellfish you **catch**? Yes No

If **yes**, provide details:

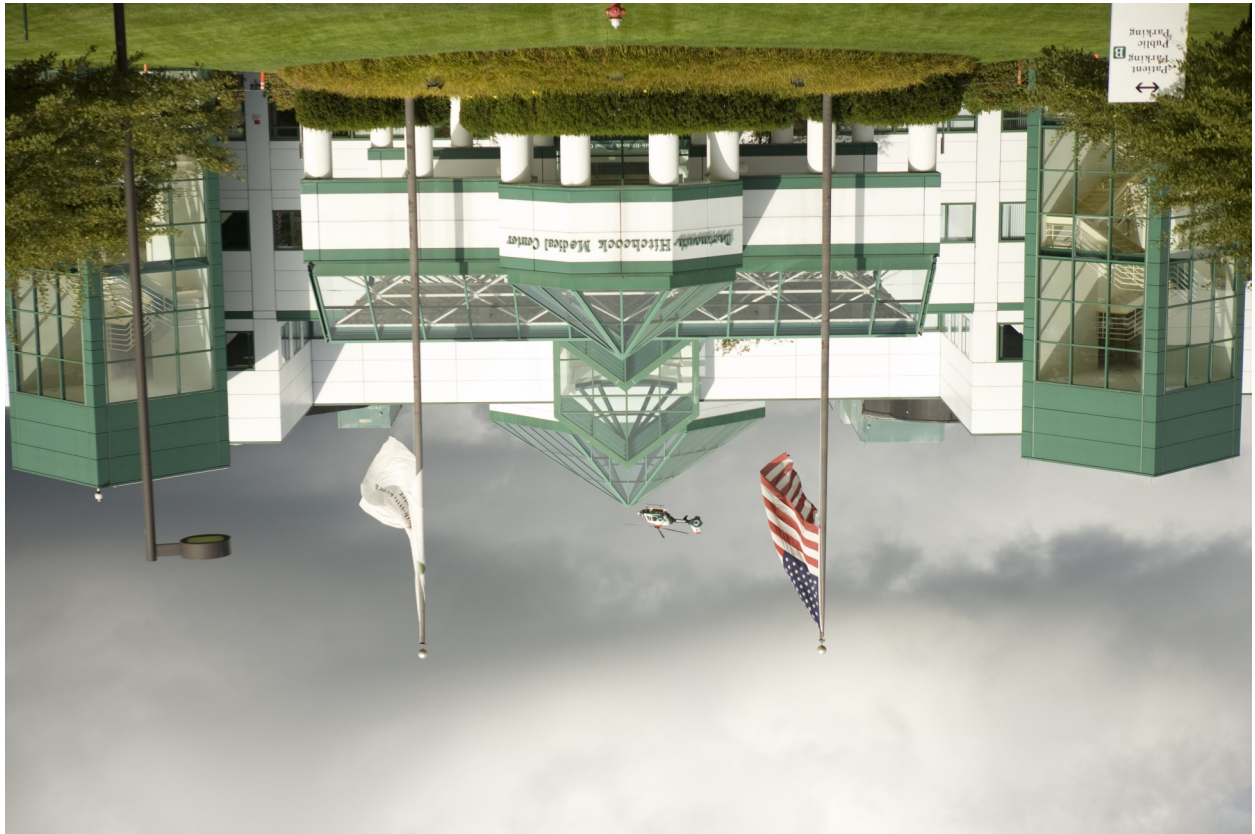
_____	_____	_____	_____	_____	_____
<i>Waterbody Name</i>	<i>Town</i>	<i>State</i>	<i>Species</i>	<i># Consumed/Year</i>	<i>Years</i>
_____	_____	_____	_____	_____	_____
<i>Waterbody Name</i>	<i>Town</i>	<i>State</i>	<i>Species</i>	<i># Consumed/Year</i>	<i>Years</i>
_____	_____	_____	_____	_____	_____
<i>Waterbody Name</i>	<i>Town</i>	<i>State</i>	<i>Species</i>	<i># Consumed/Year</i>	<i>Years</i>

28. Have you **bought** freshwater or marine fish for food more than 15 times per year? Yes No

If **yes**, please enter what types of commercially/domestically caught shellfish/fish have you **bought** and then eaten and write their names in the appropriate column(s) below? (*i.e. Clams, Oysters, Mussels, Lobster, Catfish, Trout, Anchovies, Salmon, Grouper, Cod, Snapper, Perch, Halibut, Canned Tuna, Mahi Mahi, Mackerel, Marlin, Shrimp, Scallop, Walleye, Perch, Smallmouth/Largemouth/Sea Bass, White Sucker, Carp, Bluegill, Black Crappie, White Crappie*)

Seafood Types Weekly	Seafood Types Monthly

Thank you for completing this survey.



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