Please return the completed survey to:
Nadia Steinzor, Earthworks Oil & Gas Accountability Project
PO Box 149, Willow, NY 12495
If you have questions, contact Nadia at 315-677-4111 or nsteinzor@earthworksaction.org

Health Survey of Pennsylvania Residents

Note: Please fill out a separate survey form for each person in your household

Date form is completed _____

Name _____

Age _____ Sex: [ ] Male [ ] Female

Current Address: _____Town or city _____

County: [ ] Washington [ ] Greene [ ] Butler [ ] Bradford [ ] Susquehanna [ ] Tioga
Other/name:_____

If you prefer to remain anonymous, please just note your age, sex, town, and county

How many people live in your home: full time _____ or part time_____?

May we contact you for further information? Yes _____ No_____

Phone Number _____ Email address _____

Form completed by (if other than resident): _____
Information provided by (if other than resident): _____

Location Information

1. How long have you lived at your current address?
_____ number of years, from _____ to _____

2. Where did you live previously? _____
_____ number of years, from _____ to _____

3. Did you previously live in your current County before moving?
Yes _____ No _____

If yes, how long did you live there?
_____ number of years, from _____ to _____

4. How close do you or did you live to a compressor station or pipeline station?
_____

Please indicate the operator of the compressor or pipeline station nearest to your home and any other identification information, such as location
_____
_____

5. How close do you or did you live to a gas-producing well? _____

Please indicate the operator of the well nearest to your home and any other identification information, such as location
_____
_____

6. How close do you or did you live to an impoundment pond (waste pit)?
_____

Please indicate the operator of the pond nearest to your home and any other identification information, such as location
_____
_____

Exposure

1. Please list your occupations over the last 20 years

Occupation/Company	Years (from-to)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Were you exposed to chemicals in your work place? Yes _____ No _____ Don't know_____

If yes, please list the chemicals and the years for each chemical:

Chemical	Number of Years	Years (from-to)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Were you exposed to chemicals from family members' work places that were carried into your home? Yes _____ No _____ Don't know_____

If yes, please list the chemicals and the number of years and range of years for each chemical:

Chemical	Number of Years	Years (from-to)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Smoking History
Do you smoke? Yes _____ No _____
Did you smoke in the past? Yes _____ No _____
How many years have you smoked? _____
How many packs per day? _____
Do other members of your household smoke?_____

Health Conditions

1. Healthy or Sick
Do you consider yourself Healthy _____ Sick _____
How frequently are you sick? _____ days per week ____days per month
Do you have access to doctors? Yes _____ No _____
Do you have access to Other Health Care Providers? Yes _____ No _____
Where do you go for medical assistance when you are sick?

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2. Did you have any medical conditions before shale gas development began in your area? If so, please list:

_____

_____

_____
_____
_____

3. Odors and Health Symptoms
Do you experience odors in the air? Yes _____ No _____
How frequently do you experience the odors?
Number of times per day _____
Number of days per week _____ Number of days per month _____
Please describe the odors:
_____
_____

4. Do you experience different odors when the wind is blowing from different directions?
Yes _____ No _____

If yes, please describe the different odors associated with the different wind directions:
_____
_____

5. Do you know where or what facility the odors are coming from? Yes _____ No _____

If yes, please describe the sources of odors you are experiencing
_____
_____
_____
_____

6. Please list health impacts you experience associated with specific odors:

Odor	Health Impact
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

7. Please list the length of time that the health impacts associated with odor events last.

Health Impact	Length of Time
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical Symptoms

Check all that apply; please fill out a separate form for each member of your household

Skin

___persistent skin problems
___skin rashes
___skin irritation
___hives
___boils
___changes in skin color
___sores that won't heal
___discolored areas of skin
___dry, cracked red skin
___many pinpoint dots on skin
__ burns on skin
__contact dermatitis
___eczema
___peeling hands and arms
__thickening of skin layer
__yellowing of skin

Sinus/Respiratory

___loss of sense of smell
___frequent shortness of breath
__ persistent hoarseness
__ asthma
__ sinus problems
__ abnormal lung function test
__ difficulty breathing
__ persistent cough
___wheezing
__ chronic cough
__ allergies
__nasal irritation
___throat irritation
___coughing up blood/sputum

Digestive/Stomach

___ abdominal pain
___persistent abdominal pain
___ bleeding from rectum
___change in bowel habits
___black stool
___red blood in stool
___diarrhea
___persistent indigestion
___frequent nausea
___vomiting
___vomiting blood
___loss of appetite
___weight loss

Vision/eyes

___ eye burning
___burns on eye
___conjunctivitis
___blurred vision
___dry eyes
___blindness in either eye
___severe pain in eyes
___chronic eye irritation
___difficulty in vision
___decrease in vision
___frequent tearing of eyes
___swelling of eyes
___uncontrolled eye movement
___loss of ability to see colors
___trembling of eyelids
__ yellowing of eyes

Ear/Nose/Mouth

___deafness
___hearing loss
___ringing in ears
___difficulty hearing
___frequent nose bleeds
___noises in ears
___loss of sense of taste
___discoloration of teeth
___metallic taste on cough
___gingivitis
___redness or swelling of gums
___discoloration of gums
___severe salivation
___sores or ulcers in mouth

Neurological

___loss of memory
___amnesia
___forgetfulness
___spelling difficulties
___decreased motor skills
___learning problems
___difficulty in drawing
___staggering/stumbling
___falling
___nerve damage
___tremors
___seizures
___weakness of hands
___trembling of hands/arms
___tingling of hands
___disorientation
___hallucination
___dizziness
___balance difficulty
___slurring of speech when tired
___difficulty in concentration
___memory problems

Urinary/urological

___frequent urination
___difficulty in starting urine
___blood in urine
___sugar in urine
___discolored urine
___kidney stones

Muscles/Joints

___ swollen, painful joints
___joint pain
___arthritis
___muscular pain
___muscle aches or pains
___lumbar (lower back) pain
___weakness
___reduced muscle strength

Cardiological/Circulatory

___blue lips, nose or skin
___ stroke
___irregular/rapid heart beat
___frequent chest pains
___slow heart beat
___high blood pressure
___low blood pressure
__ abnormal chest x-ray
___prolonged bleeding

Reproductive

___abnormal PAP smear
___abnormal Mammogram
___discharge from nipple
___menstrual disturbances
___bloody vaginal discharge
___infertility

Behavioral/Mood/Energy

___increased fatigue(tired)
___feeling weak and tired
___extreme drowsiness
___sleep disorders
___sleep disturbances
___depression
___loss of sexual drive
___fainting
___problems in judgment
___behavioral changes
___suicidal thoughts
___changes in personality
___severe anxiety
___tension
___compulsive behavior
___agitation
___difficulty carrying out activities
___appetite disturbances
___frequent irritation

Lymphatic/Thyroid

___lumps or swelling in neck
___lumps or swelling in armpit
___lumps or swelling in groin
___lumps in breast
___excessive sweating

Immunological

___frequent infections
___poor wound healing
___fevers of unknown cause

Other/general

___abnormal blood test
___severe headaches

Diseases

Check all that apply; please fill out a separate form for each member of your household

Kidney/Urological

___Kidney Disease
___Kidney Cancer
___Kidney Problems
___Kidney Stones
___Blood in Urine
___Frequent Urinary Tract Infections
___Bladder Disease

Bones/Joints

___Musculo-Skeletal Disease
___Osteoporosis
___Osteomalacia
___Bone Fractures
___Rheumatoid Arthritis

Liver

___Liver Cancer
___Liver Disease
___Liver Problems
___Cirrhosis of Liver
___Liver Enlargement
___Jaundice
___Angiosarcoma of Liver
___Gout
___Bile Duct Disease

Ulcers

___Ulcers of Stomach
___Ulcers of Gastrointestinal Tract

Thyroid/Lymphatic System

___Enlarged Thyroid
___Thyroid Trouble
___Endocrine Disturbances
___Sarcoidosis

Heart/Lungs

___Hypertension
___Portal Hypertension
___Pulmonary Edema
___Spots on Lungs
___Heart Disease
___Calcifications in Lungs
___Pleural Plaques
___Vascular Disease
___Asbestosis
___Cardiovascular Disease
___Silicosis
___Cardiac Arrhythmia
___Pneumoconiosis
___High Blood Pressure
___Bronchitis
___Esophageal Varices
___Pleurisy
___Tuberculosis
___Emphysema
___Asthma

Other

___Gall Stones
___Spleen Enlargement
___Raynaud's Disease
___Endometrosis
___Hepatitis
___Schleroderma

Blood disorders

___Anemia
___Aplastic Anemia
___Hemolytic Anemia
___Polycythemia
___Leukopenia
___Pancytopenia

Brain/neurological

__ Neuropathy
___Brain Tumor
___Brain Disorder
___Parkinson's Disease
___Abnormal EEG
___Cerebral Palsy
___Peripheral Neuritis
___Tremors
___Sensory Loss
___Dementia
___Amnesia

Skin/Eyes/Mouth

___Vision Impairment
___Contact Dermatitis
___Eczema
___Skin Rash
___Conjunctivitis
___Damage to Nerves or Eyes
___Corneal Disease
___Cataracts
___Gingivitis

Diabetes

___Diabetes
___Diabetes Mellitus
Diabetes Insipidus

Cancer

___Bladder Cancer
___Stomach Cancer
___Esophageal Cancer
___Masopharyngeal Cancer
___Thyroid Cancer
___Multiple Myeloma
___Malignant Melanoma
___Duodenal Cancer
___Pre-Cancerous Skin
___Skin Cancer
___Lupus
___Lung Cancer
___Reticulum Cell Sarcoma
___Hermangiosarcoma
___Gastrointestinal Cancer
___Bronchial Cancer
___Breast Cancer
___Pancreatic Cancer
___Ovarian Cancer
___Colon Cancer
___Sinonasal Cancer
___Cervical Cancer
___Uterine Cancer
___Oral Cancer
___Nasal Cancer
___Scrotal Cancer
___Cancer of Larynx
___Prostate Cancer
___Cancer of Trachea
___Bone Cancer
___Cancer of Small Intestine
___Hodgkin's Lymphoma
___Non-Hodgkin's Lymphoma
___Neuroblastoma
___Mesothelioma
___Lymphosarcoma
___Aleukemia
___Perlelukemia
___Eruthroleukemia

If available, please provide dates of diagnosis for the diseases checked above:
_____
_____
_____
_____
_____

Other health symptoms or diseases not listed on this form:
_____
_____
_____
_____
_____

Child information (if applicable)
Have you had a child/children born with:
Birth defects Yes _____ No _____ Learning disorders Yes _____ No _____
Neurological disorders Yes _____ No _____ Behavioral disorders Yes _____ No _____
Memory disorders Yes _____ No _____
Have you had a stillborn child/children Yes _____ No _____

Is there anything else you've experienced that you can tell us about (such as pet/livestock illnesses)?
_____
_____
_____
_____
_____
_____