Health Survey of Current and Former DISH/Clark Texas Residents

Name _____

Current Address _____
_____
_____

Previous Address in DISH/Clark, Texas if you no longer live in DISH/Clark, Texas

_____
_____

Phone Number _____
Age _____ Sex_____

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

How long have you lived in DISH/Clark _____number of years, from _____ to _____

Did you previously live in DISH/Clark? _____
When did you move from DISH/Clark?_____
How long did you live in DISH/Clark?_____ number of years, from _____ to _____

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

Please indicate the operator of the compressor station nearest to your home and any other identification information from the station._____
_____

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

Occupational Exposure

List your occupations over the last 20 years

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

Were you exposed to chemicals in your work place? Yes No

Please list the chemicals and the number of years and range of years for each chemical:

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

Were you exposed to chemicals from family members work places that were carried into your home Yes No

Please list the chemicals and the number of years and range of years for each chemical:

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

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?_____

Healthy or Sick

Do you consider yourself HEALTHY or SICK (please circle one)
How frequently are you sick? ____days/week ____days/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?
_____
_____

Odors and Health Symptoms

Do you experience odors in the air? Yes No
How frequently do you experience the odors?
No. of times per day _____
No. of days per week _____
No. of days per month _____

Please describe the odors _____
_____

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

Please describe the different odors associated with the different wind directions: _____
_____
_____

Do you think you know where or what facility the odors are coming from? Yes No

Please describe the sources of odors you are experiencing

_____
_____
_____
_____
_____

Health Impacts Associated with Specific Odors

Please list health impacts you experience associated with specific odors:

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

Please list the lengthy of time the health impacts associated with odor events last.

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

Please fill out one of these forms for each person living part time or full time in your home. Include the symptoms listed above.

Medical Symptoms

___skin rashes
___skin irritation
___hives
___boils
___changes in skin color
___swollen painful joints
___persistent skin problems
___sores that won't heal
___discolored areas of skin
___discoloration of teeth
___dry, cracked red skin
___dermatitis
___burns on skin
___burns on eye
___conjunctivitis
___contact dermatitis
___nasal irritation
___throat irritation
___peeling hands and arms
___eczema
___thickening of skin layer
___allergies
___eye burning
___arthritis
___blue lips, nose or skin
___loss of sense of smell
___excessive sweating
___difficulty breathing
___shortness of breathe
___wheezing
___frequent shortness of breath
___persistent hoarseness
___asthma
___sinus
___shortness of breathe
___abnormal chest x-ray
___abnormal lung function test
___bleeding from rectum
___change in bowel habits
___persistent indigestion
___persistent abdominal pain
___black stool
___red blood in stool
___vomiting blood
___abdominal pain
___frequent nausea
___vomiting
___diarrhea
___weight loss
___loss of appetite
___blood in urine
___sugar in urine
___discolored urine
___discharge from nipple
___menstrual disturbances
___bloody vaginal discharge
___birth defects in children
___stillborn children
___infertility
___increased fatigue(tired)

___persistent cough
___chronic cough
___coughing up blood/sputum
___irregular/rapid heart beat
___frequent chest pains
___slow heart beat
___blurred vision
___blindness in either eye
___severe pain in eyes
___chronic eye irritation
___difficulty in vision
___decrease in vision
___frequent tearing of eyes
___swelling of eyes
___kidney stones
___frequent urination
___difficulty in starting urine
___abnormal PAP smear
___abnormal Mammogram
___seizures
___hallucination
___loss of memory
___dizziness
___severe headaches
___forgetfulness
___depression
___fainting
___trembling of eyelids
___trembling of hands/arms
___tingling of hands
___weakness of hands
___falling or stumbling
___decreased motor skills
___compulsive behavior
___sleep disorders
___frequent irritation
___easy bruising
___many pinpoint dots on skin
___abnormal blood test
___loss of sense of taste
___joint pain
___muscle aches or pains
___lumbar pain
___disorientation
___weakness
___tremors
___nerve damage
___loss of sense of smell
___muscular pain
___stroke
___ringing in ears
___difficulty hearing
___deafness
___hearing loss
___lumps or swelling in neck
___lumps or swelling in armpit
___lumps or swelling in groin
___lumps in breast
___frequent infections
___metallic taste on cough
___poor wound healing
___gingivitis
___redness or swelling of gums
___severe salivation
___discoloration of gums
___high blood pressure
___low blood pressure
___prolonged bleeding
___frequent nose bleeds
___yellowing of skin or eyes
___fevers of unknown cause
___uncontrolled eye movement

___extreme drowsiness
___changes in personality
___severe anxiety
___learning problems
___behavioral changes
___difficulty in drawing
___difficulty in concentration
___memory problems
___inability to recall numbers
___feeling weak and tired
___difficulty carrying out activities
___appetite disturbances
___sleep disturbances
___loss of sexual drive
___balance difficult
___slurring of speech when tired
___staggering
___falling
___sores or ulcers in mouth
___dry eyes
___tension
___problems in judgment
___suicidal thoughts
___agitation
___spelling difficulties
___recall problems
___reduced muscle strength
___noises in ears
___loss of ability to see colors
___amnesia
___depression

Diseases

___Kidney Disease
___Kidney Cancer
___Kidney Problems
___Kidney Stones
___Hypertension
___Bladder Disease
___Bladder Cancer
___Blood in Urine
___Frequent Urinary Track Infections
___Liver Cancer
___Liver Disease
___Ulcers of Stomach
___Ulcers of GI tract
___Gastrointestinal Cancer
___Sensory Loss
___Vision Impairment
___Peripheral Neuropathy
___Nerve Damage
___Neuritis
___Nervous System
___Brain Tumor
___Brain Disorder

___Cirrhosis of Liver
___Liver Problems
___Liver Enlargement
___Jaundice
___Hepatitis
___Portal Hypertension
___Esophageal Varices
___Angiosarcoma of Liver
___Hermangiosarcoma
___Cancer of Pancreas
___Diabetes
___Diabetes Mellitus
___Diabetes Insipidus
___Endocrine Disturbances
___Bile Duct Disease
___Gall Stones
___Stomach Cancer
___Esophageal Cancer
___Spleen Enlargement
___Duodenal Cancer
___Colon Cancer
___Cancer of Small Intestine
___Bone Fractures
___Tremors
___Dementia
___Amnesia
___Cerebral Palsy
___Tuberculosis
___Bronchitis
___Pleurisy
___Pulmonary Edema
___Asthma
___Emphysema
___Pleural Plaques
___Spots on Lungs
___Calcifications in Lungs

___Parkinson's Disease
___Abnormal EEG
___Thyroid Cancer
___Thyroid Trouble
___Enlarged Thyroid
___Anemia
___Polycythemia
___Leukopenia
___Aplastic Anemia
___Hemolytic Anemia
___Hodgkin's Lymphoma
___Non-Hodgkin's Lym.
___Lymphosarcoma
___Aleukemia
___Perlelukemia
___Multiple Myeloma
___Pancytopenia
___Eruthroleukemia
-----Ovarian Cancer
___Musculo-Skeletal Dis.
___Osteoporosis
___Osteomalacia
___Contact Dermatitis
___Pre-Cancerous Skin
___Skin Cancer
___Eczema
___Skin Rash
___Malignant Melanoma
___Raynaud's Disease
___Schleroderma
___Lupus
___Rheumatoid Arthritis
___Gout
___Sarcoidosis
___Heart Disease
___Vascular Disease

___Asbestosis
___Silicosis
___Pneumoconiosis
___Lung Cancer
___Mesothelioma
___Bronchial Cancer
___Masopharyngeal Cancer
___Sinonasal Cancer
___Nasal Cancer
___Oral Cancer
___Gingivitis
___Cancer of Larynx
___Cancer of Trachea
___Conjunctivitis
___Damage to Nerves or Eyes
___Corneal Disease
___Cataracts

___Cardiovascular Disease
___Cardiac Arrhythmia
___High Blood Pressure
___Neuroblastoma
___Reticulum Cell Sarcoma
___Breast Cancer
___Ovarian Cancer
___Cervical Cancer
___Uterine Cancer
___Endometrosis
___Scrotal Cancer
___Prostate Cancer
___Bone Cancer

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 still born child/children Yes No

If available please provide dates of diagnosis for the diseases checked on the form:

_____
_____
_____
_____

Other symptoms or diseases not listed on the form:

_____
_____
_____
_____

Form completed by:_____

Information provided by:_____

Date: _____

Please mail or drop off the completed Health Survey Form at the DISH Town Hall.

DISH Town Hall
5413 Tim Donald Rd.
DISH, TX 76247