

Protocol Number/Title: NMRC.2014.0025: *An Observational Study of U.S. Marines in Darwin Australia*

### Pre-deployment GCE Study Questionnaire

1. Today's Date (DD/MM/YY): \_\_\_\_\_ Study ID \_\_\_\_\_
2. Place of Birth (state, country): \_\_\_\_\_
3. Age: \_\_\_\_\_ Sex (check one):  M  F
4. Race/ Ethnicity (check all that apply):  White  Black/African American  Hispanic  
 Asian  Hawaiian/Pacific Islander  
 American Indian/Native American  Multi-racial
5. RUC/UIC during this deployment: \_\_\_\_\_  UNK
6. MOS: \_\_\_\_\_
7. Grade: \_\_\_\_\_
8. Battalion: \_\_\_\_\_
9. Company: \_\_\_\_\_
10. Platoon: \_\_\_\_\_
11. Location of Previous operations: To what areas were you mainly deployed (land-based operations)? Please mark ALL that apply including the amount of time spent at each location.

If none, check this box:  N/A

Circle **One**

Area 1: \_\_\_\_\_ Time at location \_\_\_\_\_ days weeks months years

Area 2: \_\_\_\_\_ Time at location \_\_\_\_\_ days weeks months years

Area 3: \_\_\_\_\_ Time at location \_\_\_\_\_ days weeks months years

Circle **YES** or **NO**

12. Does your family have a history of diabetes? **YES** **NO**

13. Does your family have a history of chronic liver disease? **YES** **NO**

14. Does your family have a history of chronic renal (kidney) disease? **YES** **NO**

15. Personal Travel: Have you ever traveled to a tropical area of the world? Examples include South East Asia, India, Puerto Rico, Western Africa, South America. Please be specific.

If none, check this box:  N/A

Circle **One**

Area 1: \_\_\_\_\_ Time at location \_\_\_\_\_ days weeks months years

Area 2: \_\_\_\_\_ Time at location \_\_\_\_\_ days weeks months years

Area 3: \_\_\_\_\_ Time at location \_\_\_\_\_ days weeks months years

*Please continue questionnaire on reverse side.*

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### Pre-deployment GCE Study Questionnaire

16. Prior to your deployment, have you or are you experiencing any of the following symptoms? For any of the following symptoms, please indicate by circling “Yes” or “No.” Did you go see a doc (physician, PA, medic, corpsman, etc.), did you miss any work because of it (SIQ?), and are you are still bothered by the symptom now? Please do not include service-related aches and pains.

<i>Symptom</i>		<i>See the Doc?</i>		<i>SIQ?</i>		<i>Still Bothered?</i>	
		<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Fever</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Cough (lasting longer than one week)</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Headaches</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Generally feeling weak</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Muscle aches</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Swollen, stiff or painful joints</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Chest pain or pressure</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Skin disease or rashes</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>

17. Do you drink alcohol? Please circle **ONE** answer.      **YES**      **NO\***

\*If **NO**, do NOT answer the remaining questions.

18. If **Yes**, how often? Please check only **ONE**.

- Infrequently (<1 day/week)       Some days (1-3 days/week)  
 Usually (4-5 days/week)       Most days (6-7 days/week)

19. How many alcoholic drinks do you consume **per day**? Try to give an accurate daily average for an ordinary week taking into account any days of higher consumption, e.g., weekends.

Please circle **ONE** choice:

**0-1 drink**      **1-2 drinks**      **3-4 drinks**      **5-6 drinks**      **>6 drinks**

20. Do you binge drink? (More than 4 standard drinks on one occasion for a female or more than 6 standard drinks on one occasion for a male).

Please circle **ONE** choice:

**Never**      **Monthly**      **Weekly**      **More than Weekly**

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**Mid and Post-deployment GCE Study Questionnaire**

1. Today's Date (DD/MM/YY): \_\_\_\_\_ Study ID \_\_\_\_\_
2. Place of Birth (state, country): \_\_\_\_\_
3. Age: \_\_\_\_\_ Sex (check one):  M  F
4. Race/ Ethnicity (check all that apply):  White  Black/African American  Hispanic  
 Asian  Hawaiian/Pacific Islander  
 American Indian/Native American  Multi-racial
5. RUC/UIC during this deployment: \_\_\_\_\_  UNK
6. MOS: \_\_\_\_\_
7. Grade: \_\_\_\_\_
8. Battalion: \_\_\_\_\_
9. Company: \_\_\_\_\_
10. Platoon: \_\_\_\_\_

11. Location of Previous operations: To what areas were you mainly deployed (land-based operations)? Please mark all that apply, including the amount of time spent at each location.

If none, check this box:  N/A

Circle **ONE**

- Area 1: \_\_\_\_\_ Time at location \_\_\_\_\_ days weeks months years
- Area 2: \_\_\_\_\_ Time at location \_\_\_\_\_ days weeks months years
- Area 3: \_\_\_\_\_ Time at location \_\_\_\_\_ days weeks months years

Circle **YES or NO**

12. Does your family have a history of diabetes? **YES NO**
13. Does your family have a history of chronic liver disease? **YES NO**
14. Does your family have a history of chronic renal (kidney) disease? **YES NO**

15. Personal Travel: Have you ever traveled to a tropical area of the world? Examples include South East Asia, India, Puerto Rico, Western Africa, South America. Please be specific.

If none, check this box:  N/A

Circle **ONE**

- Area 1: \_\_\_\_\_ Time at location \_\_\_\_\_ days weeks months years
- Area 2: \_\_\_\_\_ Time at location \_\_\_\_\_ days weeks months years
- Area 3: \_\_\_\_\_ Time at location \_\_\_\_\_ days weeks months years

16. List specific training areas in Australia (ex.: Mt. Bunday, Shoal Water Bay), approximate duration of exercise, and any exposures to dust, soil, and surface water during that time?

Circle **ALL** that apply

- Area 1: \_\_\_\_\_ Duration \_\_\_\_\_ Exposures: Dust Soil Surface water
- Area 2: \_\_\_\_\_ Duration \_\_\_\_\_ Exposures: Dust Soil Surface water

**Please continue questionnaire on reverse side.**

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**Mid and Post-deployment GCE Study Questionnaire**

Circle **ALL** that apply

Area 3: \_\_\_\_\_ Duration \_\_\_\_\_ Exposures: Dust Soil Surface water

Area 4: \_\_\_\_\_ Duration \_\_\_\_\_ Exposures: Dust Soil Surface water

Area 5: \_\_\_\_\_ Duration \_\_\_\_\_ Exposures: Dust Soil Surface water

Area 6: \_\_\_\_\_ Duration \_\_\_\_\_ Exposures: Dust Soil Surface water

Area 7: \_\_\_\_\_ Duration \_\_\_\_\_ Exposures: Dust Soil Surface water

**17.** During your training in Australia, have you or are you experiencing any of the following symptoms? For any of the following symptoms, please indicate by circling “Yes” or “No.” Did you go see a doc (physician, PA, medic, corpsman, etc.), did you miss any work because of it (SIQ), and are you are still bothered by the symptom now? Please do not include service-related aches and pains.

<i>Symptom</i>		<i>See the Doc?</i>		<i>SIQ?</i>		<i>Still Bothered?</i>	
		<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Fever</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Cough (lasting longer than one week)</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Headaches</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Generally feeling weak</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Muscle aches</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Swollen, stiff or painful joints</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Chest pain or pressure</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Skin disease or rashes</i>	N/A	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>

**18.** Do you drink alcohol? Please circle **ONE** answer.      **YES**      **NO\***

\*If **NO**, do NOT answer the remaining questions.

**19.** If **YES**, how often? Please check only **ONE**.

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**20.** How many alcoholic drinks do you consume **per day**? Try to give an accurate daily average for an ordinary week taking into account any days of higher consumption, e.g., weekends.

Please circle **ONE** choice:

**0-1 drinks    1-2 drinks    3-4 drinks    5-6 drinks    > 6 drinks**

**21.** Do you binge drink? (More than 4 standard drinks on one occasion for a female or more than 6 standard drinks on one occasion for a male).

Please circle **ONE** choice:

**Never      Monthly      Weekly      More than Weekly**