*****Draft*** Household Survey Template ***Draft*****

Instructions to Householder: Fill out household's current address in Pompton Lakes:

Address: _____ _____, Pompton Lakes, New Jersey Date Survey Completed ___/___/____
Street number Street name

List each person who currently lives or who has ever lived in your household at this address:

Person	Name	Relationship to Person 1	Start Date of Residency at Household's Address	Current Resident at this Address?	If Not a Current Resident, End Date of Residency at Household's Address	If Not a Current Resident, Vital Status
1		Self	Month____ Year____			
2			Month____ Year____	Yes____ No____	Month____ Year____	Alive____ Unknown_____ Deceased_____ Date of death: Month ___ Year____
3			Month____ Year____	Yes____ No____	Month____ Year____	Alive____ Unknown_____ Deceased_____ Date of death: Month ___ Year____
4			Month____ Year____	Yes____ No____	Month____ Year____	Alive____ Unknown_____ Deceased_____ Date of death: Month ___ Year____
5			Month____ Year____	Yes____ No____	Month____ Year____	Alive____ Unknown_____ Deceased_____ Date of death: Month ___ Year____
6			Month____ Year____	Yes____ No____	Month____ Year____	Alive____ Unknown_____ Deceased_____ Date of death: Month ___ Year____
7			Month____ Year____	Yes____ No____	Month____ Year____	Alive____ Unknown_____ Deceased_____ Date of death: Month ___ Year____
8			Month____ Year____	Yes____ No____	Month____ Year____	Alive____ Unknown_____ Deceased_____ Date of death: Month ___ Year____

Please answer the following questions for each person in your family/household listed on page 1:

Person 1 (Self) Gender: M F Date of birth: Month_____ Year_____

Health Condition	**Q1.** During the past 12 months did you have any of the health conditions in the first column? If Yes, check box:	**Q2.** Has a doctor, nurse, or other health professional EVER told you that you have this condition? If Yes, check box: and answer Q3:	**Q3.** If yes, when were you first told that they have this condition List Month / Year:
Neurological conditions:			
Multiple sclerosis	☐	☐	_____/_____
Lupus	☐	☐	_____/_____
Circulatory conditions:			
Heart disease	☐	☐	_____/_____
Cerebrovascular/stroke	☐	☐	_____/_____
Respiratory conditions:			
COPD*	☐	☐	_____/_____
Asthma	☐	☐	_____/_____
Cancers:			
Brain cancer	☐	☐	_____/_____
Leukemia	☐	☐	_____/_____
Bladder cancer	☐	☐	_____/_____
Kidney cancer	☐	☐	_____/_____
Non-Hodgkin lymphoma	☐	☐	_____/_____
Other Cancer	☐	☐	_____/_____
Please specify:_____	☐	☐	_____/_____
Other conditions:			
Diabetes	☐	☐	_____/_____
Kidney disease	☐	☐	_____/_____
*Please specify:*_____			
Other significant health condition: *Please specify:*_____	☐	☐	_____/_____

* Chronic Obstructive Pulmonary Disease

Please answer the following questions for each person in your family/household listed on page 1 (use one form per person). If person is deceased, skip Q1 and go directly to Q2.

Person #___ Gender: M F Date of birth: Month_____ Year_____

Health Condition	**Q1.** During the past 12 months did this person have any of the health conditions in the first column? If Yes , check box:	**Q2.** Has a doctor, nurse, or other health professional EVER told this person that they have or had this condition? If Yes, check box: and answer Q3:	**Q3.** If yes, when was this person first told that they had this condition List Month / Year:
Neurological conditions:			
Multiple sclerosis	☐	☐	_____/_____
Lupus	☐	☐	_____/_____
Circulatory conditions:			
Heart disease	☐	☐	_____/_____
Cerebrovascular/stroke	☐	☐	_____/_____
Respiratory conditions:			
COPD*	☐	☐	_____/_____
Asthma	☐	☐	_____/_____
Cancers:			
Brain cancer	☐	☐	_____/_____
Leukemia	☐	☐	_____/_____
Bladder cancer	☐	☐	_____/_____
Kidney cancer	☐	☐	_____/_____
Non-Hodgkin lymphoma	☐	☐	_____/_____
Other cancer	☐	☐	_____/_____
Please specify:_____	☐	☐	_____/_____
Other conditions:			
Diabetes	☐	☐	_____/_____
Kidney disease	☐	☐	_____/_____
*Please specify:*_____			
Other significant health condition: *Please specify:*_____	☐	☐	_____/_____

* Chronic Obstructive Pulmonary Disease