World Trade Center Health Registry
2022 Multiple Chemical Sensitivity Survey

INSTRUCTIONS:

- **Please fill in circles completely using a black or blue ink pen.** → **Example:** ○ ● ○
- **Written answers should be printed in capital letters.** → **Example:** J A 1 2

This survey contains questions that will help the Registry understand how multiple chemical sensitivity (MCS) has affected your life and your health. We will use MCS throughout this survey.

1. **Please enter today's date:**

M M / D D / Y Y Y Y

2. **What is your date of birth?**

M M / D D / Y Y Y Y

3. **What sex were you assigned at birth?**
   - ○ Female
   - ○ Male
   - ○ Neither female nor male

	Yes	No
4. **Do you feel sick when you are exposed to tobacco smoke, certain fragrances, nail polish/remover, engine exhaust, gasoline, air fresheners, pesticides, paint/thinner, fresh tar/asphalt, cleaning supplies, new carpet or furnishings? By sick we mean: headache, difficulty thinking, difficulty breathing, weakness, dizziness, upset stomach, etc.**	○	○
5. **Are you unable to tolerate or do you have adverse or allergic reactions to any drugs or medications (such as antibiotics, anesthetics, pain relievers, X-ray contrast dye, vaccines or birth control pills), or to an implant, prosthesis, contraceptive chemical or device, or other medical/surgical/dental material or procedure?**	○	○
6. **Are you unable to tolerate or do you have adverse reactions to any foods such as dairy products, wheat, corn, eggs, caffeine, alcoholic beverages, or food additives (for example, MSG, food dye)?**	○	○

→ ***If you answered "No" to Questions 4,5, and 6 → Go to Question 18***

7. The following items ask about your responses to various odors or chemical exposures. Please indicate whether or not these odors or exposures would make you feel sick, for example, you would get a headache, have difficulty thinking, feel weak, have trouble breathing, get an upset stomach, feel dizzy, or something like that. For any exposure that makes you feel sick, on a 0-10 scale rate the severity of your symptoms with that exposure. For exposures that do not bother you, answer "0". Do not leave any items blank.

[0=not at all a problem] [5=moderate symptoms] [10=disabling symptoms]

	0	1	2	3	4	5	6	7	8	9	10
a. Diesel or gas engine exhaust	○	○	○	○	○	○	○	○	○	○	○
b. Tobacco smoke	○	○	○	○	○	○	○	○	○	○	○
c. Insecticide	○	○	○	○	○	○	○	○	○	○	○
d. Gasoline, for example at a service station while filling the gas tank	○	○	○	○	○	○	○	○	○	○	○
e. Paint or paint thinner	○	○	○	○	○	○	○	○	○	○	○
f. Cleansing products such as disinfectants, bleach, bathroom cleansers or floor cleaners	○	○	○	○	○	○	○	○	○	○	○
g. Certain perfumes, air fresheners or other fragrances	○	○	○	○	○	○	○	○	○	○	○
h. Fresh tar or asphalt	○	○	○	○	○	○	○	○	○	○	○
i. Nail polish, nail polish remover, or hairspray	○	○	○	○	○	○	○	○	○	○	○
j. New furnishings such as new carpeting, a new soft plastic shower curtain or interior of a new car	○	○	○	○	○	○	○	○	○	○	○

8. Name any additional chemical exposures that make you feel ill and score them from 0 to 10.

[0=not at all a problem] [5=moderate symptoms] [10=disabling symptoms]

	0	1	2	3	4	5	6	7	8	9	10
a. Other chemical 1 (Please specify):	○	○	○	○	○	○	○	○	○	○	○
b. Other chemical 2 (Please specify):	○	○	○	○	○	○	○	○	○	○	○
c. Other chemical 3 (Please specify):	○	○	○	○	○	○	○	○	○	○	○
d. Other chemical 4 (Please specify):	○	○	○	○	○	○	○	○	○	○	○
e. Other chemical 5 (Please specify):	○	○	○	○	○	○	○	○	○	○	○

9. The following items ask about your responses to a variety of other exposures. As before, please indicate whether these exposures would make you feel sick. Rate the severity of your symptoms on a 0-10 scale. Do not leave any items blank.

[0=not at all a problem] [5=moderate symptoms] [10=disabling symptoms]

	0	1	2	3	4	5	6	7	8	9	10
a. Chlorinated tap water	○	○	○	○	○	○	○	○	○	○	○
b. Particular foods, such as candy, pizza, milk, fatty foods, meats, barbecue, onions, garlic, spicy foods, or food additives such as MSG	○	○	○	○	○	○	○	○	○	○	○
c. Unusual cravings, or eating any foods as though you were addicted to them; or feeling ill if you miss a meal	○	○	○	○	○	○	○	○	○	○	○
d. Feeling ill after meals	○	○	○	○	○	○	○	○	○	○	○
e. Caffeine, such as coffee, tea, Snapple, cola drinks, Big Red, Dr. Pepper or Mountain Dew, or chocolate	○	○	○	○	○	○	○	○	○	○	○
f. Feeling ill if you drink or eat less than your usual amount of coffee, tea, caffeinated soda or chocolate, or miss it altogether	○	○	○	○	○	○	○	○	○	○	○
g. Alcoholic beverages in small amounts such as one beer or a glass of wine	○	○	○	○	○	○	○	○	○	○	○
h. Fabrics, metal jewelry, creams, cosmetics, or other items that touch your skin	○	○	○	○	○	○	○	○	○	○	○
i. Being unable to tolerate or having adverse or allergic reactions to any drugs or medications (such as antibiotics, anesthetics, pain relievers, X-ray contrast dye, vaccines or birth control pills), or to an implant, prothesis, contraceptive chemical or device, or other medical, surgical or dental material or procedure	○	○	○	○	○	○	○	○	○	○	○
j. Problems with any classical allergic reactions (asthma, nasal symptoms, hives, anaphylaxis or eczema) when exposed to allergens such as: tree, grass or weed pollen, dust, mold, animal dander, insect stings or particular foods	○	○	○	○	○	○	○	○	○	○	○

10. The following questions ask about symptoms you may have experienced commonly. Rate the severity of your symptoms on a 0-10 scale. Do not leave any items blank.

[0=not at all a problem] [5=moderate symptoms] [10=disabling symptoms]

	0	1	2	3	4	5	6	7	8	9	10
a. Problems with your muscles or joints, such as pain, aching, cramping, stiffness or weakness?	○	○	○	○	○	○	○	○	○	○	○
b. Problems with burning or irritation of your eyes or problems with your airway or breathing, such as feeling short of breath, coughing, or having a lot of mucus, post-nasal drainage, or respiratory infections?	○	○	○	○	○	○	○	○	○	○	○
c. Problems with your heart or chest, such as a fast or irregular heart rate, skipped beats, your heart pounding, or chest discomfort?	○	○	○	○	○	○	○	○	○	○	○
d. Problems with your stomach or digestive tract, such as abdominal pain or cramping, abdominal swelling or bloating, nausea, diarrhea, or constipation?	○	○	○	○	○	○	○	○	○	○	○
e. Problems with your ability to think, such as difficulty concentrating or remembering things, feeling spacey, or having trouble making decisions?	○	○	○	○	○	○	○	○	○	○	○
f. Problems with your mood, such as feeling tense or nervous, irritable, depressed, having spells of crying or rage, or loss of motivation to do things that used to interest you?	○	○	○	○	○	○	○	○	○	○	○
g. Problems with balance or coordination, with numbness or tingling in your extremities, or with focusing your eyes?	○	○	○	○	○	○	○	○	○	○	○
h. Problems with your head, such as headaches or a feeling of pressure or fullness in your face or head?	○	○	○	○	○	○	○	○	○	○	○
i. Problems with your skin, such as a rash, hives or dry skin?	○	○	○	○	○	○	○	○	○	○	○
j. Problems with your urinary tract or genitals, such as pelvic pain or frequent or urgent urination? (For people who menstruate: discomfort or other problems with your menstrual period?)	○	○	○	○	○	○	○	○	○	○	○

11. The following items refer to *ongoing* exposures you may be having. Select "NO," if you did not have the exposure or if you don't know whether you have the exposure. Select "YES," if you do have the exposure. Do not leave any items blank.

	No	Yes
a. Do you smoke or dip tobacco once a week or more often?	○	○
b. Do you drink any alcoholic beverages, beer, or wine once a week or more often?	○	○
c. Do you consume any caffeinated beverages once a week or more often?	○	○
d. Do you routinely (once a week or more) use perfume, hairspray, or other scented personal care products?	○	○
e. Has either your home or your workplace been sprayed for insects or fumigated in the past year?	○	○
f. In your current job or hobby, are you routinely (once a week or more) exposed to any chemicals, smoke or fumes?	○	○
g. Other than yourself, does anyone routinely smoke inside your home?	○	○
h. Is either a gas or propane stove used for cooking in your home?	○	○
i. Is a scented fabric softener (liquid or dryer sheet) routinely used in laundering your clothes or bedding?	○	○
j. Do you routinely (once a week or more) take any of the following: steroid pills, such as prednisone; pain medications requiring a prescription; medications for depression, anxiety, or mood disorders; medications for sleep; or recreational or street drugs?	○	○

12. If you are sensitive to certain chemicals or foods, on a scale of 0-10 rate the degree to which your sensitivities have affected various aspects of your life. If you are not sensitive or if your sensitivities do not affect these aspects of your life, answer "0." Do not leave any items blank.

How much have your sensitivities affected:
[0=not at all] [5=moderate] [10=severely]

	0	1	2	3	4	5	6	7	8	9	10
a. Your diet?	○	○	○	○	○	○	○	○	○	○	○
b. Your ability to work or go to school?	○	○	○	○	○	○	○	○	○	○	○
c. How you furnish your home?	○	○	○	○	○	○	○	○	○	○	○
d. Your choice of clothing?	○	○	○	○	○	○	○	○	○	○	○
e. Your ability to travel to other cities or drive a car?	○	○	○	○	○	○	○	○	○	○	○
f. Your choice of personal care products, such as deodorants or makeup?	○	○	○	○	○	○	○	○	○	○	○
g. Your ability to be around others and enjoy social activities, for example, going to meetings, church, restaurants, etc.?	○	○	○	○	○	○	○	○	○	○	○
h. Your choice of hobbies or recreation?	○	○	○	○	○	○	○	○	○	○	○
i. Your relationship with your spouse or family?	○	○	○	○	○	○	○	○	○	○	○

13. How old were you when your chemical intolerance or sensitivities began?

☐☐ Years of age ○ Do not recall ○ Not applicable

14. Do you believe your World Trade Center exposure initiated your MCS chemical intolerance or sensitivities or made existing symptoms worse?

- ○ Made your existing symptoms worse
- ○ Initiated your MCS chemical intolerance or sensitivities → *Go to Question 16*
- ○ Not applicable

15. If you believe World Trade Center exposure made your sensitivities worse, identify the degree to which your intolerances have worsened.

[0=not at all] [5=moderate] [10=severely]

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

16. Was there a particular exposure that you believe initiated your chemical intolerance or sensitivities? *Select **one** only.*

- ○ New construction or remodeling at home, work or school
- ○ Surgical, medical, or dental procedure, or a particular medication
- ○ Breast implants
- ○ Prolonged course of antibiotics for any persistent, difficult to treat infection(s)
- ○ Chemical exposure or spill (not pesticide related)
- ○ Pesticide, Insecticide or Herbicide
- ○ Combustion products (home or building fire, wildfire)
- ○ Mold
- ○ I don't know
- ○ None, I do not believe I had an initiating event
- ○ Other exposure such as military, occupational, carbon monoxide, gas leak, 9/11.
  Please explain: _____

17. Over your lifetime, have you taken a long-course of antibiotics for any persistent, difficult to treat infection(s): *Select all that apply.*

- ○ Ear infection(s)
- ○ Tonsillitis
- ○ Sinus infection(s)
- ○ Tooth, jaw, mouth, dental infection or procedure
- ○ Root canal
- ○ Pneumonia, bronchitis or other airway infection
- ○ Gastrointestinal illness or infection
- ○ Skin or nail infection (acne)
- ○ Urinary tract infection (UTI) or kidney infection
- ○ Vaginitis
- ○ Prostate infection
- ○ Wound, injury, or post-surgical infection
- ○ Fungal, yeast, or Candida infection (Candidiasis)
- ○ No prolonged antibiotic prescriptions
- ○ Other (please specify): _____

The following questions refer to your medical visit(s) for symptoms related to MCS or chemical intolerance or sensitivities.

18. Have you seen a physician or health care provider regarding your symptoms related to MCS or chemical intolerance or sensitivities?

- ○ Yes
- ○ No
- ○ Not applicable → *Go to Question 29*

19. How many providers have you consulted about MCS or chemical intolerance or sensitivities?

- ○ 1
- ○ 2
- ○ 3
- ○ 4 or more → *Go to Question 23*

20. Did you feel your symptoms and concerns were taken seriously?

- ○ Yes
- ○ No

21. Did you feel the provider listened carefully to you?

- ○ Yes
- ○ No

22. Did you receive sufficient time to discuss your concerns?

- ○ Yes
- ○ No → *Go to Question 27*

23. If you have seen more than one provider for MCS or chemical intolerance or sensitivities, were some satisfactory and others not?

- ○ Yes
- ○ No

24. How many providers did you feel your symptoms and concerns were taken seriously?

- ○ 0
- ○ 1
- ○ 2
- ○ 3 or more

25. How many providers did you feel listened carefully to you?

- ○ 0
- ○ 1
- ○ 2
- ○ 3 or more

26. How many providers gave you sufficient time to discuss your concerns?

- ○ 0
- ○ 1
- ○ 2
- ○ 3 or more

27. Select the type of provider(s) that you found helpful for your MCS-related symptoms or chemical intolerance or sensitivities: *Select all that apply.*

- ○ Allergist or immunologist
- ○ Anesthesiologist
- ○ Dermatologist
- ○ Emergency medicine
- ○ Family medicine
- ○ Internal medicine
- ○ Medical genetics
- ○ Neurologist
- ○ Nurse Practitioner
- ○ Obstetrics and gynecology
- ○ Ophthalmology
- ○ Pathologist
- ○ Physical medicine and rehabilitation
- ○ Preventive medicine
- ○ Psychiatrist
- ○ Oncologist
- ○ Surgeon
- ○ Urologist
- ○ Other (please specify):

_____

28. Overall, how satisfied were you with your most recent MCS-related medical visit?

[0=not at all] [5=moderately satisfied] [10=extremely satisfied]

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

29. Would you be open to sharing more details about your personal experience with MCS at a later time?

- ○ Yes
- ○ No
- ○ Not applicable

The following information is requested to help confirm that this survey was completed by or for the enrollee it was sent to. This information will remain strictly confidential. If you would like to provide this information over the phone, please call us at 866-692-9827.

30. What are the last four digits of your Social Security Number?

31. Please use the space below to tell us anything else about your experience with MCS.

_____

_____

_____

_____

This is the end of the survey.
Thank you for completing the 2022 Multiple Chemical Sensitivity Survey.
We appreciate your input and will keep your answers confidential.

Please return the completed survey in the provided envelope.
If the envelope was not included or was lost, call us at 866-692-9827.
