Australian



Gulf War Veterans’

Health Study

2003

volume

3

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**Volume 3**

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1. Mailout materials

Dear

I am writing to you to invite and encourage you to participate in the Australian Gulf

War Veterans Health Study.

This study will add to our understanding of any health effects which may have arisen from service in the Gulf War, and to our knowledge of the health of members of the Australian Defence Force. This study should also provide useful knowledge to assist with future deployment planning. A successful study will enable us to assess the need for future health support to our Veteran community.

The study has the full support of the ex-service community, and of the Australian

Defence Force.

For the study to be successful, it is vital that as many individuals as possible participate. This includes those who feel that they enjoy good health, as well as those who are unwell, those that went to the Gulf as well as those who did not. A high participation rate is required in order to obtain useful results. If you decide to participate in the study, you will be helping all of those who served and you will be provided with an assessment of your current health. All the expense associated with the study will be met by the Department of Veterans’ Affairs, including your travel expenses.

The study will be conducted by an independent medical research team headed by

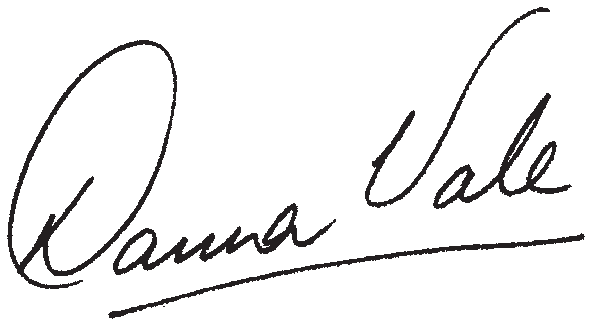
Monash University. The records will be subject to the provisions of the *Privacy Act*

*1988* which regulate their use, storage and disclosure. Ethics committees have approved this study on the proviso that your results will not be used by the Department of Veterans’ Affairs or Defence for any purpose without your written consent. On the other hand, you may use the information concerning yourself any way you see fit.

This study is important for both Gulf War Veterans and other members of the

Australian Defence Force and I urge you to participate.

Yours sincerely



DANNA VALE MP

Dear

The Gulf War Veterans’ Health Study Consultative Forum was formed to act as bridge between the team responsible for studying the health of those serving at the

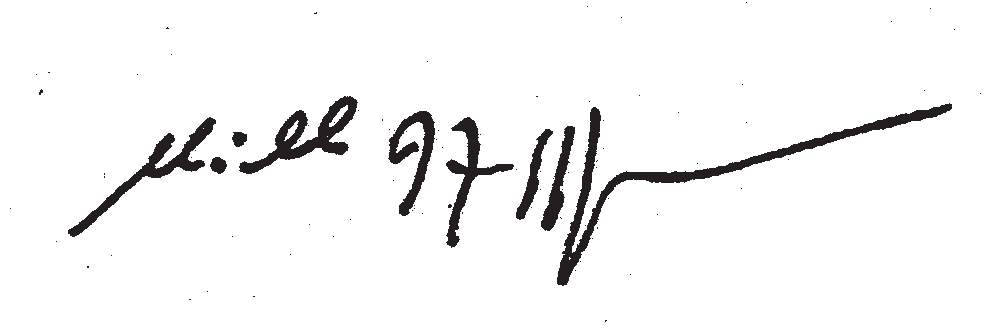
time of the Gulf War, and the broader veteran community. The Forum is composed of representatives of many veteran and service organisations. On your behalf, we have been involved in the formulation of this Study. We strongly support this Study.

In designing the Study, great care has been taken to ensure confidentiality for all participants – particularly for those who are still members of the Defence Force. As explained in the material enclosed with this letter, safeguards are built into the Study that will ensure that the data that relates to you as a person will remain private.

The Study is very important, not only to Gulf War veterans, but also to all veterans of overseas deployments – in fact, to all in the Australian Defence Force.

Because the success of this Study depends on the numbers who volunteer to participate, we urge you to be in it.

Yours sincerely,



David Watts

Australian Gulf War Veterans Association

David Wilson Mike Flynn

Warrant Officer Navy Naval Association of Australia

Organisations represented on the Gulf War Veterans’ Health Study Consultative Forum: AVADSC

TPI Federation

Naval Association of Australia

Regular Defence Force Welfare Association Armed Forces Federation of Australia Australian Gulf War Veterans Association

National Consultative Group of Service Families

RSL

Australian Defence Force



**Monash University and Health Services Australia**



**invite you to participate in the**

**Gulf War Veterans' Health Study**

This Study aims to determine whether the health status of Australia's Gulf War Veterans differs from that of Australian Defence Force personnel who were not deployed to the Gulf, and whether any such differences can be associated with Gulf War-related activities or experiences. The Study is being undertaken by medical researchers at Monash University and Health Services Australia (HSA) who are independent of the ADF and DVA. The study is funded by the Australian Government.

**In brief, participation in the Study involves:**

➊ **Completing a questionnaire about your Service experiences and your health.**

➋ **Attending a Health Services Australia Clinic for a medical examination, mental health assessment and routine tests.**

*This package should contain most of the information you need in order to make an informed decision about participation in the Study*.

**Specifically you will find enclosed:**

• Letters of support from the Minister for the Department of Veterans' Affairs and Assisting the Minister for Defence and from the Consultative Forum to this study.

• A comprehensive Explanatory Statement (blue) identifying the procedures and requirements related to participation in the Study.

• A copy of the study Consent Form (yellow). This outlines your rights as a Study participant and the obligations of the Study Investigators. You may choose to consent to some or all of the items on the form.

• A phone contact page (green) - outlining how to contact the Study teams to indicate your interest in participating, or to discuss any questions you have about the study.

**Other things you should know:**

★Participants will receive a copy of their examination results for their personal use.

★There are HSA clinics in each of Australia's capital cities and also in several of the large towns. HSA will endeavour to tailor their appointment times to suit you.

★Participants can claim reimbursement for any loss of income, travel or accommodation costs associated with attending the medical examination.

★Participation in the Study is entirely voluntary; you are under no obligation to take part. If you do choose to participate you may withdraw at any time.

★Individual assessment results are **entirely confidential**. This very important aspect of the Study is outlined, in more detail, in the blue Explanatory Statement.

**PTO**

**What you should do now:**

☛ Please read the enclosed information, particularly the Explanatory statement and

Consent form (NB. Donít sign the form now, you can do that at the time of participation)

☛ If you would like to ask any further questions please phone the Study Contact and Recruitment team on **1800 502 302** – they will endeavor to answer your questions or to refer you to the most appropriate alternative source of information.

**YOUR DECISION:**

�**YES, I'LL PARTICIPATE**

Please phone the Study Contact & Recruitment team on **1800 502 302.** All of the

necessary arrangements will be made for you. (please see the green contact page for times to call from your State)

�**STILL NOT SURE**

Please think about it, maybe talk to a friend who has participated or has been invited to,

perhaps talk to your local Veterans Association, call the Contact and Recruitment team again or call the Study Investigators (see green contact page for their number).

�**NO, I would not like to participate**

Please phone **1800 502 302** to register your voluntary refusal. This has several purposes:

• We will know that you have received the Study information package, and we will flag your record to prevent you receiving reminder notices about participation. This saves you aggravation, and saves us lots of time.

• It is very important to the Study to know a little about those who decline to participate. For example, if you decline participation due to ill-health this information is very important to the overall Study goal of comparing the health of Gulf War Veterans with that of non-Gulf War Service personnel.

By participating in this Study you will be contributing valuable knowledge to both civilian and Defence Force communities about the health impacts of Service related activities & experiences. This knowledge may assist you or other Service personnel (current or former) in gaining recognition for Service-related ill-health. It may also assist the ADF in developing the most appropriate supportive & protective measures against future health threats. Finally, participation offers you the opportunity to take part in a confidential, free and comprehensive medical examination; the results of which you can keep for your own records and use.

**Thanks:**

Many thanks for your consideration of this invitation. The Study team feel very privileged to be involved in this Study and trust that you will too. We have a rare opportunity to understand more fully the activities, experiences and associated health impacts among our valued veterans and Servicemen & women. We look forward to documenting your experience soon.



**Associate Professor Malcolm Sim Dr Michael Pincus**



Monash University Health Services Australia

Explanatory statement: **Australian Gulf War Veterans' Health Study**

***Introduction***

Independent medical researchers at Monash University and Health Services Australia are undertaking a health study of military personnel who were in the Australian Defence Forces around the time of the Persian Gulf War with Iraq in late

1990 and early in 1991. This study is funded by the Australian Government.

The study aims to determine whether Defence Force activities at that time, particularly any preparation or experience related to the Gulf War, may have resulted in any adverse health effect on Australian Defence Force personnel. The study includes Defence Force personnel who were not deployed to the Gulf War as a comparison group. The inclusion of veterans who did not go to the Gulf is also important to identify other service related activities which may affect health.

***Participation overview***

Your active participation in the study will involve two parts. The first part involves the completion of a multi-faceted questionnaire about aspects of your Service experience, other work history, your general health, medical history and life-style. In most instances, the questionnaire may take approximately one and a half hours to complete and this can be done in your own time at home.

The second part of the study consists of a comprehensive medical examination to be conducted at a Health Services Australia (HSA) Clinic. The medical examination will involve several different types of tests. They include an interviewer administered mental health questionnaire, some additional clinician administered health questions, blood and urine tests for infections, routine blood counts and tests of liver and kidney functioning, neurological examination, breathing tests, skin tests for common allergens including house dust mites, cats, grasses and mould, a brief test of your fitness, and measures of height, weight and blood pressure. Internal examinations will NOT be performed. However you will be physically examined by a doctor and will be required to remove some clothing. The complete medical assessment at HSA, including questionnaires, could take up to 5 hours to complete. All assessments will be conducted by trained and qualified medical personnel.

You will be asked about medical conditions which your children may have. We would like to check any reports of childhood cancer or malformations with the records held by the National Cancer Registry and the National Childhood Malformations Registry. We will only check these national records with your signed consent to do so.

Similarly, but in the future, we would like to check the names of all participants in the Study against the records of the National Cancer and National Death Registries. This may help us to determine if there are any long term health differences between the Gulf War Veterans and those Servicemen and women not deployed to the Gulf. We seek your consent to include your name in these checks.

You will be sent a copy of your medical assessment results, within a few weeks of your appointment, and you will be invited to nominate a medical practitioner to also receive a copy. If any medical condition, identified during the conduct of the medical examination, requires more immediate treatment or investigation, a letter will be provided to you to take to your regular medical practitioner for follow-up. Alternatively the HSA clinician may feel it necessary to contact your regular practitioner directly, in which case your consent will be sought for that purpose.

It should be emphasised that participation in all parts of the study is voluntary. There is no obligation to take part in this study. Further you may choose to participate in some but not all components of the Study. If you do initially choose to take part you may withdraw at any time with no detriment to your career or hindrance to access to appropriate medical care. Serving Australian Defence Force personnel who choose not to participate, or choose to withdraw, will not be subject to detriment to their career as a result of that decision.

***Risks and inconveniences***

Risks and inconveniences involved with participation include time and travel incurred, the possibility of some emotional distress in answering questions about life and

Service experiences, and mild discomforts associated with some test procedures. More specifically, actual participation in the study may take more than six hours, including self-administered questionnaire and medical assessment, but not including travel time associated with attendance at an appropriate HSA clinic. Where possible

appointments for medical assessments will be made at times and locations convenient to you and, if necessary, travel and accommodation arrangements will be made on your behalf**. Travel and accommodation costs will be borne by the DVA**. **DVA can also reimburse participants for any loss of income incurred as a result of participation in the medical examination**. Those participants who are

current members of the Defence Forces will be regarded as on duty while travelling and participating in the examination.

The interviewer administered mental health survey may include questions about stressful or upsetting experiences or questions which elicit unpleasant or distressful memories or feelings. This survey instrument will be administered by a qualified clinical psychologist experienced in the use of such instruments, sensitive to the feelings of the participant, and bound by a professional code of ethics and confidentiality.

The skin test for allergies is painless but often results in a small itching red weal on the skin of participants allergic to the tested substance, much like an insect bite. This reaction usually disappears after approximately fifteen minutes and participants can be treated with a cream to relieve itchiness. In extremely rare cases, in individuals highly allergic to a tested substance, a shock-like reaction can occur. This reaction is easily identified and all HSA clinics are staffed by trained medical personnel and equipped with the necessary medical equipment for such emergency situations.

Breathing tests involve filling your lungs and blowing in to a spirometer which measures lung volume. This can result in mild breathlessness similar to that which results from blowing up a balloon. Participants may rest in between each blow and the procedure will be strictly monitored and carried out according to internationally approved standards.

The fitness test will involve stepping up and down from a 16 inch platform for three minutes. Your heart rate will be measured upon completion of this test. This test may result in a moderate level of breathlessness.

The taking of a blood sample from a vein in the arm may cause a brief pricking sensation. Occasionally bruising or tenderness may result, which on rare occasions, may persist for a few days. Blood samples will be taken by a registered nurse.

***Blood storage***

Blood taken for the purpose of routine and immediate pathological investigations will be destroyed within days of collection. An extra sample of your blood will be frozen

and stored for approximately twelve months. This allows us to run additional tests, if necessary, to explain any specific clusters of symptoms which may become evident in the study group as the Study progresses. After 12 months these samples will also be destroyed.

We would, however, also like to freeze and store a sample of your blood serum indefinitely. Blood serum is part of the fluid in which blood cells are suspended. For the purpose of long-term storage the genetic material is removed leaving non-genetic containing particles and the liquid serum. The purpose of this serum storage is to enable us to test for any new conditions that might become apparent in the future without the requirement to obtain another blood sample from you. The blood serum will never be used by the study team without your written consent and our purpose is to only ever use it for medical research.

***Confidentiality and privacy – What will happen to your data?***

All of the information gained in the study will be held securely by Monash University for a minimum of 7 years. You can ask Monash for, and receive a copy, of your assessment results for your own use in that time. To ensure the confidentiality of the information the data will have all identifying information removed and will be held in storage using code numbers.

The Department of Veterans' Affairs will store a set of this deidentified data indefinitely and the code will be kept by the secretary of the DVA Ethics Committee. You will continue to have access to this information for your own use. The information, however, can not be accessed by DVA to assess compensation or pension claims. DVA can only access the information for the purpose of medical research and only with the approval of an overseeing committee which includes representatives from Veteran's groups.

The Department of Defence will not have access to the data, which relates to you. In extreme circumstances some information may be subject to mandatory reporting

legislation or obtainable, by a third party, via a court order.

The results of all of the material gathered will be statistically analysed in grouped format, published in a Report to the Government and in articles in medical journals. It will not be possible to identify any individualís results from these publications or reports.

***Future investigations***

To assist us, in assessing long term health effects, we may need to contact you in the future. This may be to ask you about your health or to invite you to participate in

future studies. This may assist us to avoid unnecessary checks of the National Death Registry for persons known to be alive, and to validate matches made with the National Cancer registry. If we do contact you, you will be under no obligation to participate in any proposed investigations.

We may be able to answer some questions, which arise from this study, by reviewing some of the medical records that are held by the Australian Defence Force. Your medical record can only be accessed with your signed consent.

***Concerns or complaints***

Should you have any concerns or complaints about the manner in which this project is conducted, please do not hesitate to contact the study team on **1800 062 534**.

The principal investigator for this study is: Associate Professor Malcolm Sim

Department of Epidemiology & Preventive Medicine

Monash University

Level 3 553 St Kilda Rd Melbourne VIC 3004

Telephone: 1800 062 534 Fax: (03) 9903 0556

If the study team cannot satisfactorily address your concerns or complaints you may wish to consider contacting one of several committees who are responsible for endorsing various aspects of the study procedures.

The study is being conducted under the auspices of an independent Scientific

Advisory Committee. The chairperson of the Scientific Advisory Committee is:

Professor Terry Dwyer University of Tasmania Menzies Centre

17 Liverpool Street

Hobart TAS 7000

Telephone: (03) 6226 7702 Fax: (03) 6226 7704

There is also a Consultative Forum of representatives of the veteran community. They have written a separate letter to you.

Alternatively you may prefer to contact the Ethics Committees which have endorsed the procedures within the study. They are the Australian Defence Medical Ethics Committee and the Monash University Standing Committee on Ethics in Research Involving Humans (SCERH). They are contactable at the following addresses:

Executive Secretary

Australian Defence Medical Ethics Committee

CP2-7-67

Department of Defence

Canberra ACT 2600

Telephone: (02) 6266 3818 Fax: (02) 6266 4982

The Secretary

Standing Committee on Ethics in Research Involving Humans Monash University *(please quote project number 2000/140)* Wellington Rd

Clayton VIC 3800

Telephone: (03) 9905 2052 Fax: (03) 9905 1420

INFORMED CONSENT STATEMENT

**Gulf War Veterans Health Study**

I agree to take part in the Gulf War Veterans Health Study. I have had the aims of the project, and the procedures therein, satisfactorily explained to me and I have had the opportunity to read and ask questions arising from the Explanatory Statement. In signing this consent form I am declaring the following:

I have read and understand the information about the Study and have had explained to me the

**1** aims of this research project, and the procedures in which I will be involved.

I understand that I will need to devote time to completing the various parts of the study including a self-administered questionnaire and a medical examination.

I understand that I will have blood taken for testing.

I understand that there are some inconveniences and risks involved in participation including potential emotional distress, associated with answering questions about my Service or life experiences, and mild discomfort associated with procedures such as skin testing, fitness testing, breathing tests and blood sampling.

I understand that I am participating in this project in a voluntary capacity and that I can withdraw at any time. This withdrawal will be without penalty or detriment to career or hindrance to future medical care.

I understand that if any medical condition, requiring further investigation or treatment, is found as a result of the medical examination, the appropriate feedback will be provided to me or to my nominated medical practitioner.

I am co-operating in this project on condition that:

• the information I provide and results of my assessments will be kept confidential and only used for this project.

• the research reports will be made available to me at my request and

• any published reports of this study will preserve my anonymity

I agree that a sample of my blood serum may be stored indefinitely for potential and further

**2** medical research. This serum can not be used for any such purpose without my further specific written consent.



I agree that the researchers may check the records of the National Cancer Registry and National

**3** Childhood Malformations Registry against information I provide about my childrensí health.

**4** I agree that the researchers may check my name against the records of the National Cancer

Registry and National Deaths Registry.

**5** I also agree that the researchers may obtain my Australian Defence Force medical record.

**I consent to all of the above points 1 to 5.**

Name.............................................................. HSA Witness ...................................................

Signed......................................................

/ /\_ Signed................................................... / /

**OR**

**I consent to all of the above points except number/s (please specify).**

Name.............................................................. HSA Witness ...................................................

Signed....................................................

/ /

Signed................................................... / /

**TO CONTACT THE STUDY TEAMS**

The **Gulf War Veterans Health Study Contact & Recruitment**

**Team** are available to:

� *register your intention to participate, or to not participate, in the Study*

� *answer any queries you have about participation in the study*

� *refer you on to an alternative and appropriate source of information if they*

*are unable to answer a question*

Please call them on **1800 502 302** during the following times, Monday to

Friday, from your State. This is a free call from anywhere within Australia.

**8.30am – 4.30pm** for NSW, ACT, VIC & TAS

**8.00am – 4.00pm** from SA & NT

**7.30am – 3.30pm** from QLD

**5.30am – 1.30pm** from WA

If these times are not suitable you may call at any time and leave a message. Please be sure to include, in your message, your full name, phone contact details and some information about when you can best be contacted at that phone number. The Contact & Recruitment team will call you back as soon as possible.

Alternatively you can **email** the team on [**GulfWar.HealthStudy@dva.gov.au**](mailto:GulfWar.HealthStudy@dva.gov.au) to register your intention to participate, or to not participate, in the Study. Please be sure to include, in your email, your full name, phone contact details and some information about when you can best be contacted at that phone number. The Contact & Recruitment team may need to speak to you directly by phone.

If you would like to speak directly with the **Monash University and Health Services Australia Gulf War Veterans Health Study Investigators**, please phone them directly on **1800 062 534**. This is a free call from anywhere within Australia. They should be able to answer any questions you may have about participating, or refer you to alternative source of information if necessary.

**WE LOOK FORWARD TO HEARING FROM YOU SOON**

2. Telephone questionnaire for non-participants

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***REFUSER QUESTIONNAIRE* STUDY NUMBER**

**1. Is the participant willing to complete a short questionnaire?**

❏ No ❏ Yes

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

day month year

❏ Not answered

**3.**  **Were you a serving Defence Force member in August** ❏ No ❏ Yes ❏ Not answered

**1990?**

**4.**  **In which country** ❏ Australia

**were you born?** ❏ UK & Ireland

❏ Italy

❏ Greece

❏ Netherlands

❏ Germany

❏ New Zealand

❏ Malaysia

❏ USA

❏ Canada

❏ South Africa

❏ Other

please specify

❏ Not answered

Cease interview. The subject was not eligible to participate in the study.

**5.**  **Do you regard yourself as being of Aboriginal or** ❏ NO ❏ YES ❏ Not answered

**Torres Strait Islander origin?**

**6.**  **Which category best describes the highest Choose one.**

**educational qualification you have completed?** ❏ Primary school up to grade 6

❏ Secondary school up to grade 10

❏ Secondary school grades 11-12

❏ Certificate (trade, apprenticeship, technicians etc)

❏ Diploma (associate, undergraduate)

❏ Undergraduate degree

❏ Post-graduate degree

❏ Not answered

**7. What is your current occupational status?**

**Choose the most relevant option.**

❏ Still serving with ADF

❏ Other paid employment full-time

❏ Other paid employment part-time/casual

❏ Volunteer/community work

❏ Student

❏ Home duties

❏ Retired

❏ Not working due to ill-health / TPI

❏ Unemployed

❏ Other ( please specify )

❏ Not answered

Occupation? Industry?

Occupation? Industry?

**8. Are you a current smoker, former smoker or have you never smoked?**

Current smoker

❏

Former smoker

❏

Never smoked

❏

Not answered

❏

**9. In general, would you say your health is:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Excellent | Very good | Good | Fair | Poor | Not answered |
| ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |

**10. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

Yes, Yes,

**Does your health limit you in:** limited limited

a lot a little

a. **Moderate activities**, such as moving a ❏ ❏

table, pushing a vacuum cleaner, bowling,

or playing golf

b. Climbing **several** flights of stairs ❏ ❏

No, not Not answered limited at

all

❏ ❏

❏ ❏

**11. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have you:** | | | | |
| a. b. | **You accomplished less** than you would like You were limited in the **kind** of work or other activities | ❏ YES  ❏ YES | ❏ NO  ❏ NO | ❏ Not answered  ❏ Not answered |

**12. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| a. | **You accomplished less** than you would like | ❏ YES | ❏ NO | ❏ Not |
| answered | | | | |
| b. | You didn't do work or other activities as **carefully** as | ❏ YES | ❏ NO | ❏ Not |
|  | usual |  |  | answered |

**13. During the past 4 weeks, how much did pain interfere with your normal work**

**(including both work outside the home and housework)?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Not at all | A little bit | Moderately | Quite a bit | Extremely | Not answered |
| ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |

**14. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.**

All of the Most of A Good Some of A Little None of Not

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a. | Have you felt calm | Time  ❏ | the Time  ❏ | Bit of the  Time  ❏ | the Time  ❏ | of the  Time  ❏ | the Time  ❏ | answered  ❏ |
|  | and peaceful? |  |  |  |  |  |  |  |
| b. | Did you have a lot of  energy? | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |
| c. | Have you felt  downhearted and | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |
|  | blue? |  |  |  |  |  |  |  |

**15. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?**

All of m

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| the time Most of the time Some of the time A little of the ti | | | | e None of the time | Not answered |
| ❏ | ❏  | ❏ | ❏ | ❏ | ❏ |

3. Appointment confirmation package

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***Australia's leading health assessment and advisory service***



[name field]

[address field] Ref: [number field]

Dear [name field]

Thank you for agreeing to participate in the Gulf War Veterans Health Study.

Your participation in the Study involves completing a postal questionnaire and attending for a detailed medical examination.

As discussed, your medical examination will be conducted by staff at Health Services Australia (HSA). Our office is located on the **4th floor at Casselden Place, 2 Lonsdale Street (corner of Spring St), Melbourne**. This is very close to Parliament station.

**Your appointment time is on [fields for day of week, date, month, year] at [time field].**

Please allow **at least four and a half hours** for your complete medical examination, including breaks. You will be provided with a complimentary voucher to purchase refreshments at a local cafe.

The **postal questionnaire** is included in this package. This may take an hour and a half or more to complete. Please do your best to complete all sections **prior** to your appointment with us.

Please read the attached instruction sheet before attending your appointment. If, for any reason, you are unable to attend at the arranged time please telephone us immediately on **1300 361 046 or 9224 8376**.

The Department of Veterans Affairs can arrange, on your behalf, any travel or transport requirements between your home or work place and our office. This arrangement includes full coverage of associated costs. *Please telephone them on (03) 9284 6000 to arrange this*. If you prefer to arrange your own travel you can be reimbursed for any costs incurred including parking, petrol, public transport fares, etc. **Please keep your receipts**.

We look forward to your involvement in this very important Study. Very best regards

on behalf of the Gulf War Veterans Health Study team

[date field]

*4th Floor, Casselden Place, 2 Lonsdale Street, MELBOURNE VIC 3000; GPO Box 9821, MELBOURNE VIC 3001*

***Telephone: 03 9224 8334*** *Facsimile: 03 9224 8330* [*Email: hsa.vic@healthoz.com.au*](mailto:hsa.vic@healthoz.com.au)

**Gulf War Veterans Health Study**

**INSTRUCTIONS FOR PARTICIPANTS**

***In the week prior to your medical appointment at Health Services Australia (HSA):***

• Please take the time to read through and COMPLETE the **postal questionnaire**. The questionnaire should take approximately an hour and a half to complete. You may need several sittings to properly complete all sections. It could be useful to look up your personal records such as your medical records, W.H.O. yellow vaccination booklet, or a job resume to most accurately answer some sections.

***In the four days prior to your appointment at HSA:***

• Please avoid, if possible, the use of anti-histamine based medications typically used for cold, flu and hayfever symptoms. Examples of these are Sinutab, Codral, Demazin, Claratyne and Sudafed.

• Expect to receive a phone call from your allocated HSA office to confirm your appointment details. If you have any questions about attendance, please take this opportunity to ask them.

***On the day of your appointment at HSA:***

• Please avoid, if possible, drinking any alcohol.

• Please avoid, if possible, the use of asthma medications such as Ventolin, Becotide and

Brondecon.

*IMPORTANT*

*It is important that you do not endanger your health in any way by withholding these medications. Please do not hesitate to use any medications if your symptoms necessitate this.*

***In the hour prior to your appointment at HSA:***

• Please avoid, if possible, drinking coffee and smoking cigarettes or other nicotine containing products.

***When attending your appointment at HSA:***

• Please wear flat shoes and light, comfortable clothes (remember there will be a brief fitness test).

• Please bring your completed postal questionnaire.

• *Gulf War Vets only*: If you still have your W.H.O. yellow vaccination booklet, please bring this with you.

You do not need to fast prior to your appointment.

*How to claim for*



Travelling Expenses

**Check you have the right form**

**1**

Use the form ‘Claim for Travelling Expenses’ to claim for expenses relating to your visits to a health provider for treatment or a disability claim. For other expenses (for example travel relating to the Veterans’ Review Board or Administrative Appeals Tribunal) you will need a different form - contact your State Office or Veterans’ Advice Network (VAN).

**Complete your details and sign the front**

**2**

Write your name, DVA file number, contact phone number and address on the front of the form, then sign the declaration.

**Use a different form for each provider you visit**

**3**

If you are claiming for travel to different doctors or other health providers, you must use a separate form for each provider you visited. You need to give the form to your provider so they can complete the blue sections.

**Lodge your form with DVA within three (3) months**

**4**

You must lodge your form within three (3) months of the first travel you are claiming for. Claims received after three (3) months cannot be paid. You do not need to wait until you have filled up the form (5 visits). When you lodge your form, another form will be sent to you.

Completing the form

*Details about your travel expenses*

|  |
| --- |
| **VETERAN to complete** |
| Date and time of visit |
| Give details of all transport and parking used for each visit (total there and back)  ◆ Public transport = bus, tram, train, ferry  ◆ Community = transport by a community organisation  ◆ Arranged by DVA = transport supplied or paid by DVA |
| Did you travel FROM HOME? |
| Accommodation used for each visit  ◆ Commercial = hotel, motel etc.  ◆ Subsidised = hostel, special hospital unit etc.  ◆ Private = family, friends, etc. |

You need to give separate details about each visit to the health provider.

For example:

John Veteran’s first visit that he is claiming for was at 9am on January

6 2000.

He travelled 320km to the appointment and 320km back home (total 640km). He travelled in a private

**VISIT 1**

**A**

6 1 00 9

Private vehicle

|  |  |
| --- | --- |
| 640 km | |
| km | |
| $ |  |
| $ |
| $ |
| $ 10 |

Public transport

Taxi Community Air

Parking fees

am /—pm

Attach receipts

vehicle and had parking fees of $10. He stayed overnight in a motel.

**A** You need to take note of the date of the first visit you are claiming for. You must lodge your claim within 3 months of this date.

**B** You need to attach

Arranged by DVA

Yes X

No If you answered ‘No’, write the address you travelled from

Number

of nights

receipts for travelling

expenses such as

**B**

Commercial 1 Attach

accommodation

(see page 5 for more information about receipts).

Subsidised

Private

receipts

**2**

Your situation

*What if I have different*

*travel arrangements?*

Different kinds of travel are covered by this form. Depending on

how you travel, you need to write the distance you travelled or the amount you paid in fares. If you write the amount in fares (for example if you travel by taxi, community transport or air) you will need to attach receipts. If you are travelling from somewhere

**VISIT 2**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
| 14 | 1 | 00 | 9 am /—pm |

Private vehicle

|  |  |  |
| --- | --- | --- |
| km | |  |
| km | |  |
| $ 48.50 |  |  |
| $ |
| $ |
| $ |

Public transport

Taxi **C**

Community Attach

other than your home, you need to write the address from which you travelled in the space provided.

For example:

At the time of John Veteran’s second visit to this health care provider, he is staying with his sister and takes a taxi to his appointment. His taxi fare is $23.50 there and $25.00 back. He writes the total in the

Air Parking fees Arranged by DVA

Yes

receipts

box provided. He also writes his sister’s address in the box provided.

**C** John needs to attach the receipt from his taxi (see page 5 for more information about receipts).

*What if I need someone to travel with me?*

If you need someone to travel with you for medical reasons, you may be able to claim some of their expenses. Your health care provider must indicate on the form whether or not an attendant is medically required.

No X If you answered ‘No’, write the

address you travelled from

20 National Crescent Australia Bay

**VISIT 2**

Unable to use private/public transport X

Attendant medically required X

**3**

Completing the form

If you are admitted to hospital for any length of time, please use the

space on the back of the form to give details of your stay in hospital. Remember to fill in details about your discharge as well as your admission.

For example:

*If you are admitted to hospital*

**ADMISSION**

|  |
| --- |
| **VETERAN to complete** |
| Dates and times |
| Give details of all transport and parking used.  Give separate details for the trip there (for admission) and the trip back (after discharge).  ◆ Public transport = bus, tram, train, ferry  ◆ Community = transport by a community organisation  ◆ Arranged by DVA = transport supplied or paid by DVA |
| Did you travel FROM HOME? |
| Accommodation used for this visit  ◆ Commercial = hotel, motel etc.  ◆ Subsidised = hostel, special hospital unit etc.  ◆ Private = family, friends, etc. |
| If you had a MEDICALLY REQUIRED ATTENDANT  Did your attendant travel home and then return for you on discharge?  Number of nights your attendant used COMMERCIAL accommodation while you were in hospital |

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
| 15 | 2 | 00 | 8 a—m / pm |

TRANSPORT FOR ADMISSION ONLY Private vehicle

|  |  |
| --- | --- |
| km | |
| km | |
|  | |
| $ |  |
| $ |
| $ |
| $ |

Public transport

Taxi

John Veteran is admitted to hospital for one week in February 2000. He was transported via ambulance from his sister’s home.

On discharge he left the

Community

Air Parking fees Ambulance X

Arranged by DVA

Attach receipts

hospital by private vehicle.

Yes No X

Commercial Subsidised Private

If you answered ‘No’, write the address in the white space

Number of nights

Attach receipts

Yes No

Attach receipts –

a contributing allowance

**4** may be paid by DVA

About

receipts

**DISCHARGE**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
| 22 | 2 | 00 | 8 a—m / pm |

Depending on your particular travel and accommodation arrangements, we may need to see your receipts for some of the travel you have undertaken for your condition. Please make sure that you attach receipts securely to your form.

TRANSPORT AFTER DISCHARGE ONLY Private vehicle

|  |  |
| --- | --- |
| 21 km | |
| km | |
|  | |
| $ |  |
| $ |
| $ |
| $ |

Public transport

Taxi

**Veteran Cove Parking Station**

**6 January 2000**

**Total $10.00**

**TERRIFIC TAXIS TERRIFIC TAXIS**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**14 January 2000**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

Community

Air Parking fees Ambulance

Arranged by DVA

20 National Crescent

Australia Bay

Attach receipts

**Pick up 08:15**

**Set down 08:47**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Distance 20km**

**Extras —**

**Tariff $23.50**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

AUSTRALIAN MOTEL

HOSPITAL ROAD, VETERAN COVE 2000

Mr & Mrs J Veteran

21 Park Street

Barrack Flats

*Accommodation Tariff*

1 Night, Standard Double Room $90.00

In: 5 January 2000

Out: 6 January 2000

*Total* **$90.00**

**5**

the health provider

*Confirming the travel details*

Your health provider needs to complete the blue section of the form.

The provider must also sign the certification.

**DOCTOR or other HEALTH PROVIDER to complete**

Condition treated (for White Card only) For each visit, indicate any special

requirements due to veteran’s medical condition

**VISIT 1**

Unable to use private/public transport

Attendant medically required X

7Provider’s surname & initials

Dr I Jones

STAMP OR PRINT

Address

**at which**

**treatment occurred**

No. & street Suburb/town Postcode

Contact phone

10 Australia Street

Veteran Cove

2000

(02) 7890 7890

Provider Number for treatment address

34569A

If you are admitted to

**HOSPITAL to complete**

**ADMISSION DISCHARGE**

hospital, your health provider needs to complete the blue section

Indicate any special requirements due to veteran’s medical condition

Hospital name

|  |
| --- |
| Veteran Cove Hospital |
| 20 Hospital Road |
| Veteran Cove |
| 2000 |
| (02) 2000 2000 |
|  |

Unable to use private/public transport X

Attendant medically required

STAMP OR PRINT

Unable to use private/public transport

Attendant medically required X

Condition treated (for White Card only)

on page 4 of the form.

The provider must also sign the certification.

Address

**at which**

**treatment occurred**

No. & street Suburb/town Postcode

Contact phone

**CERTIFICATION**

I certify that I have provided treatment on the dates shown and that the details

I have provided are correct.

Signature

Provider Number for treatment address

Admitting doctor Type of provider

Dr I Jones Cardiologist

Print name

**6**

To the best of your knowledge, did the treatment meet the health care needs of the veteran and are you the **closest**

**practical** provider able to administer the required treatment?

Yes X No

Date

22 2 00

**VISIT 2**

**VISIT 3 VISIT 4**

Unable to use private/public transport X

Attendant medically required X

Unable to use private/public transport

Attendant medically required

Unable to use private/public transport

Attendant medically required

Type of provider

Cardiologist

Reason for visit(s): Treatment X

Disability claim

For treatment visits: To the best of your knowledge, did the treatment meet the health care needs of the veteran and are you the **closest practical** provider able to administer the required treatment?

Yes X

No

**CERTIFICATION**

I certify that I have provided treatment on the dates shown and that the details

I have provided are correct.

Signature

Date

14 1 00

Remember

Even if you choose to leave your form with your health provider, it is your responsibility to ensure that your form reaches DVA within three (3) months of the first visit for which you are claiming expenses.

**7**

more information

For further assistance to complete the form or to obtain further copies of the form, please ring the State

National Toll Free Number

Queensland

1800 113 304 (07) 3223 8666

Office numbers shown right, or your local VAN Office.

Other information is available in the booklet ‘Your guide to The Repatriation Transport Scheme’ or in the following DVA Fact Sheets. You can get a copy of any of the fact sheets from your State Office or VAN, or you can download them from the DVA website: [www.dva.gov.au](http://www.dva.gov.au/)

New South Wales (02) 9213 7777

|  |  |
| --- | --- |
| Victoria | (03) 9284 6000 |
| South Australia | (08) 8290 0462 |
| Tasmania | (03) 6221 6740 |
| Western Australia | (08) 9366 8222 |

HSV02 Overview of the Repatriation Transport Scheme

HSV120 Ambulance

HSV121 Travel with an Authorised Attendant

HSV122 Transport—Meal and Accommodation Allowances

HSV123 Transport—Community Transport

HSV124 Private Motor Vehicle, Bus, Train, Tram and Ferry Travel and Parking Expenses

HSV125 Taxi, Booked Car and Air Travel

HIP80 Providers—Transport Information for Health Providers

P330 – April 2000

**8**



D800

**Use this form for**

travel relating to treatment or a disability claim.

**Do NOT use this form for**

travel relating to the Administrative Appeals

Tribunal, the Veterans’ Review Board or the Specialist Medical Review Council. Use a different form – contact your State Office or Veterans’ Affairs Network (VAN) office.

**Information**

For information, please read ‘Your Guide to the Repatriation Transport Scheme’ and DVA fact sheets, available from your State Office or VAN, or visit our website [www.dva.gov.au](http://www.dva.gov.au/)

**Filling in your claim**

*Claim for*

Travelling Expenses

**Veteran to complete and sign**

Your surname

Given names DVA File Number Contact phone

HOME ADDRESS Number and street

Suburb/town

Postcode

**Complete a separate form for each health provider visited.**

You must complete the **BROWN** parts, and your doctor or other health provider must complete the **BLUE** parts.

Number and street Suburb/town Postcode

POSTAL ADDRESS (if different to home address)

For ADMISSION TO HOSPITAL, please use the back page.

Please print neatly in BLOCK LETTERS using a

BLACK or BLUE PEN.

**3 months claim period**

To receive payment for travel, you must lodge the form within 3 months after that travel (only in exceptional circumstances will DVA extend the period).

**Send your claim to**

**Department of Veterans’ Affairs**

**GPO Box 9998 in your State capital city.**

**Privacy**

The information provided is required to assess your claim for travelling expenses under the Veterans’ Entitlements Act 1986. The Act requires that a claim be made on this form as approved by the Repatriation Commission. We may disclose some of the information provided on this form to your doctor or health provider, or to the Health Insurance Commission in order to verify your claim. We may also provide information to the Department of Finance and Administration to facilitate payment of your claim.

**DECLARATION** I declare that the details I have provided in this form are correct to the best of my knowledge.

I have attached all required receipts to this form. I understand that giving false or misleading

information is a serious offence.

YOUR SIGNATURE Date

If you are a person authorised to act on behalf of the veteran in matters relating to this claim, please give your name

Remember!

**Attach** all required receipts.

**Complete and sign** the section above.

**Lodge** your form **within 3 months** of the travel you are claiming for.

**Office use** Claim ID Amount paid $

PAGE 1 D800 02/02

**Use this page to claim for visits for treatment or a disability claim. For admi**

**VISIT 2**

|  |
| --- |
| **VISIT 1** |
| Private vehicle  Public transport  Taxi  Community Attach  Air receipts  Parking fees  Arranged by DVA |
| Yes  No If you answered ‘No’, write the address you travelled from |
| No  Yes Name of attendant |
| Number of nights  Commercial Attach  Subsidised receipts  Private |

|  |
| --- |
| **VETERAN to complete** |
| Date and time of visit |
| Give details of all transport and parking used for each visit (total there and back)  ◆ Public transport = bus, tram, train, ferry  ◆ Community = transport by a community organisation  ◆ Arranged by DVA = transport supplied or paid by DVA |
| Did you travel FROM HOME? |
| Did you travel with an ATTENDANT? |
| Accommodation used for each visit  ◆ Commercial = hotel, motel etc.  ◆ Subsidised = hostel, special hospital unit etc.  ◆ Private = family, friends, etc. |

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
|  |  |  | am / pm |

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
|  |  |  | am / pm |

Private vehicle

|  |  |
| --- | --- |
| km | |
| km | |
| $ |  |
| $ |
| $ |
| $ |

|  |  |
| --- | --- |
| km | |
| km | |
| $ |  |
| $ |
| $ |
| $ |

Public transport

Taxi Community Air

Parking fees

Arranged by DVA

Attach receipts

Yes

No If you answered ‘No’, write the address you travelled from

No

Yes Name of attendant

Commercial Subsidised Private

Number of nights

Attach receipts

**DOCTOR or other HEALTH**

**PROVIDER to complete VISIT 1**

**VISIT 2**

Specify condition treated (for **White Card** only)

For each visit, indicate any special requirements due to veteran’s medical condition

Unable to use private vehicle or public transport?

Attendant medically required?

Yes No

Yes No

Unable to use private vehicle or public transport?

Attendant medically required?

Yes No

Yes No

By signing for each visit, you, the doctor/health provider certify that you saw the veteran for treatment that day and the details entered are correct

Date Date

**Before this claim can be lodged**

Type of provider

Please make sure you (the doctor or other health provider) have completed **ALL** of the following details

Provider number

Reason for visit(s): Treatment

Disability claim

To the best of your knowledge, did the treatment meet the health care needs of the veteran and are you the **closest practicable** provider able to administer the required treatment?

Yes

No

**ssion to hospital, please use the back page. Fix receipts here**

**VISIT 3**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
|  |  |  | am / pm |

|  |
| --- |
| **VISIT 4** |
| Private vehicle  Public transport  Taxi  Community Attach  Air receipts  Parking fees  Arranged by DVA |
| Yes  No If you answered ‘No’, write the address you travelled from |
| No  Yes Name of attendant |
| Number of nights  Commercial Attach receipts  Subsidised  Private |

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
|  |  |  | am / pm |

|  |
| --- |
| **VISIT 5** |
| Private vehicle  Public transport  Taxi  Community Attach  Air receipts  Parking fees  Arranged by DVA |
| Yes  No If you answered ‘No’, write the address you travelled from |
| No  Yes Name of attendant |
| Number of nights  Commercial Attach receipts  Subsidised  Private |

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
|  |  |  | am / pm |

Private vehicle

|  |  |
| --- | --- |
| km | |
| km | |
| $ |  |
| $ |
| $ |
| $ |

Public transport

Taxi Community Air

Parking fees

Arranged by DVA

Attach receipts

|  |  |
| --- | --- |
| km | |
| km | |
| $ |  |
| $ |
| $ |
| $ |

|  |  |
| --- | --- |
| km | |
| km | |
| $ |  |
| $ |
| $ |
| $ |

Yes

No If you answered ‘No’, write the address you travelled from

No

Yes Name of attendant

Commercial Subsidised Private

Number of nights

Attach receipts

**VISIT 3**

**VISIT 4**

**VISIT 5**

Unable to use private vehicle or public transport?

Attendant medically required?

Yes No

Yes No

Unable to use private vehicle or public transport?

Attendant medically required?

Yes No

Yes No

Unable to use private vehicle or public transport?

Attendant medically required?

Yes No

Yes No

Date Date Date

Provider’s surname & initials

|  |
| --- |
|  |
|  |
|  |
|  |
| Postcode |
|  |
|  |

STAMP OR PRINT

Address

**at which**

**treatment occurred**

No. & street Suburb/town Contact phone

Remember!

**You must lodge** your form

**within 3 months** of the travel you are claiming for.

**ADMISSION TO HOSPI TAL For other types of visits, please use the other side.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
|  |  |  | am / pm |

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
|  |  |  | am / pm |

|  |  |
| --- | --- |
| km | |
| km | |
|  | |
| $ |  |
| $ |
| $ |
| $ |

|  |  |
| --- | --- |
| km | |
| km | |
|  | |
| $ |  |
| $ |
| $ |
| $ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **VETERAN to complete** |  | **ADMISSION** |  | **DISCHARGE** |
| Dates and times |
| Give details of all transport and parking used.  Give separate details for the trip there (for admission) and the trip back (after discharge).  ◆ Public transport = bus, tram, train, ferry  ◆ Community = transport by a community organisation  ◆ Arranged by DVA = transport supplied or paid by DVA | **TRANSPORT FOR ADMISSION ONLY**  Private vehicle  Public transport  Taxi  Community Attach  Air receipts  Parking fees  Ambulance  Arranged by DVA | **TRANSPORT AFTER DISCHARGE ONLY**  Private vehicle  Public transport  Taxi  Community Attach  Air receipts  Parking fees  Ambulance  Arranged by DVA |
| Did you travel FROM HOME?  Yes No What address did you travel from? | | | | |
| Accommodation used for this visit  ◆ Commercial = hotel, motel etc. Number of nights: Commercial Attach  ◆ Subsidised = hostel, special Subsidised receipts  hospital unit etc.  ◆ Private = family, friends, etc. Private | | | | |
| Did you travel with an ATTENDANT? Name of your attendant  No Yes Give details  Did your attendant travel home and  then return for you on discharge? No Yes  Number of nights your attendant  used COMMERCIAL accommodation Attach receipts – a contributing while you were in hospital allowance may be paid by DVA | | | | |

**HOSPITAL to complete**

**ADMISSION DISCHARGE**

Indicate any special requirements due to veteran’s medical condition

Unable to use private vehicle or public transport?

Yes No

Unable to use private vehicle or public transport?

Yes No

Attendant medically required? Yes No

Attendant medically required? Yes No

STAMP OR PRINT

Specify condition treated (for **White Card** only)

Address

**at which**

**treatment occurred**

Hospital name

No. & street

Suburb/town

Contact phone

**CERTIFICATION**

I certify that I have provided treatment on the dates shown and that the details I have provided are correct.

Signature

Provider Number for treatment address

|  |
| --- |
|  |
|  |
|  |
|  |
| Postcode |
|  |
|  |
|  |
|  |

Admitting doctor Type of provider

Print name

To the best of your knowledge, did the treatment meet the health care needs of the veteran and are you the **closest practicable** provider able to administer the required treatment?

Yes No

Date

4. Postal questionnaire

iv

**STUDY NUMBER**



**GULF WAR VETERANS'**



HEALTH STUDY

**PARTICIPANT QUESTIONNAIRE**

OFFICE USE ONLY

PRE EXAM.

POST EXAM

**THANK YOU**

**for participating in the Gulf War Veterans Health Study**

**Please read the following instructions regarding the completion of this questionnaire.**

1. This questionnaire is to be completed by both Gulf War Veterans and other serving or former ADF members, who did not deploy to the Gulf War, but who have been invited to participate in the Gulf War Veterans' Health Study.

2. For the purpose of this study, YOU ARE A GULF WAR VETERAN IF **you were deployed**

**in support of the Gulf War during the period of 2nd August 1990 to 4th September 1991 as part of ADF Operation Ozone, Operation Damask and Operation Habitat, or with overseas forces as part of Desert Shield and Desert Storm.**

The Gulf War Veteran Group does NOT include:

i) those personnel who were on other Defence duties in the Middle East at the time,

ii) personnel deployed in support of Operation Blazer after 4th September

1991,

iii) personnel deployed in support of Operation Damask after 4th

September 1991.

If you are not sure whether you are a Gulf War Veteran, or are not a Gulf War Veteran, according to the above definition, the names of all those included in this Study's Gulf War Veteran group are published in the Gulf War Nominal Roll. The Nominal Roll can be viewed at [*http://www.dva.gov.au/commem/nomroll/gulf/index.htm*](http://www.dva.gov.au/commem/nomroll/gulf/index.htm). Alternatively you could call 1800 502 302 to check

if you are included.

RIGHT

3. When completing the questionnaire please  **TICK** ✔ **ONLY** those boxes corresponding to your answers.

Please **DO NOT** place crosses ✕ in the boxes or circle the boxes ❏

WRONG

4. Parts of the questionnaire are complicated to complete. Please be sure to read each question, and its instructions, VERY CAREFULLY.

5. Please be sure to ring the Study team if you are unsure about how to complete any section of this questionnaire. The freecall number is **1800 062 534**. Please call any time during business hours, Monday to Friday.

**Question 1.**

**For the purpose of this study do you regard yourself as a Gulf War Veteran or NOT a Gulf War Veteran?** Please refer to the definition provided on the previous page if you are not certain.

Please tick one.

|  |  |  |
| --- | --- | --- |
| ❑ | I a | m a Gulf War Veteran |
|  | → | You should complete ALL sections of this questionnaire. |
|  | → | Some tables in this questionnaire have columns labeled  “Everyone” and columns labeled “GW Vets only”; you should |
|  |  | complete BOTH columns where applicable. |

|  |  |  |
| --- | --- | --- |
| ❑ | I a  → | m NOT a Gulf War Veteran  You should complete ALL sections of this questionnaire |
|  |  | EXCEPT section C and any other questions marked “Gulf War |
|  |  | Veterans Only” |
|  | → | Some tables in this questionnaire have columns labeled  “Everyone” and columns labeled “GW Vets only”; you should |
|  |  | complete ONLY the columns labeled “Everyone”. |

**SECTION A: PERSONAL DETAILS**

We have some general questions to begin with.

**A1. Are you male or female?** ❏ Male ❏ Female

**A2. What is your date birth?**

/ / 1 9

day month year

**A3. In which** ❏ Australia please specify which State or Territory

**country were you** ❏ UK & Ireland

❏ Greece

❏ Netherlands

❏ Germany

❏ New Zealand

❏ Malaysia

❏ USA

❏ Canada

❏ South Africa

❏ Other

please specify

|  |  |  |
| --- | --- | --- |
| **A4. If NOT Australian born, what year did** | 19 |  |
| **you first arrive in Australia** | | |
| **A5. Do you regard yourself as being of** | ❏ NO | ❏ YES |
| **Aboriginal or Torres Strait Islander origin?** | | |
| **A6. What language do you usually speak in your household** | ❏ English |  |
| ❏ Other | | |
| please specify | | |
| **A7. What is your current marital status?** | **Choose one.** | |
| ❏ Married | | |
| ❏ De facto | | |
| ❏ Separated | | |
| ❏ Divorced | | |
| ❏ Widowed | | |
| ❏ Single, never married | | |
| ❏ Other | | |

please specify

**A8. Since August 1991 has your marital Select all that apply. status changed?** Since August 1991 I have:

❏ Not changed my marital status

❏ Married, or started living with a partner

❏ Separated from a partner

❏ Divorced from a partner

❏ Been widowed

❏ Other

please specify

**A9. Which category best describes the highest educational qualification you have completed?**

**A10. What is your current occupational status?**

**A11. Since August 1991 have you had a period of unemployment greater than 3 months?**

**A12. What is your main source of income now?**

**Choose one.**

❏ Primary school up to grade 6

❏ Secondary school up to grade 10

❏ Secondary school grades 11-12

❏ Certificate (trade, apprenticeship, technicians etc)

❏ Diploma (associate, undergraduate)

❏ Undergraduate degree

❏ Post-graduate degree

**Choose the most relevant option.**

❏ Paid employment full-time

❏ Paid employed part-time/casual

❏ Volunteer/community work

❏ Student

❏ Home duties

❏ Retired

❏ Not working due to ill-health / TPI

❏ Unemployed

❏ Other

please specify

❏ NO ❏ YES

**If YES, was this period of unemployment primarily due to health problems?**

❏ NO ❏ YES

**Choose one**

❏ Wage or salary

❏ Own business or share in a partnership

❏ Disability pension

❏ Other government pension/allowance/benefit

❏ Child allowance

❏ Superannuation/annuity

❏ Dividends/interest/income from investments

❏ Other

please specify

*GO TO SECTION B*

**SECTION B: MILITARY POSTINGS**

**B1. When you joined the ADF for military service were you:**

|  |  |  |
| --- | --- | --- |
| ❏ Navy ❏ Army  **B2. What year did you first join the ADF?** 19 | ❏ Airforce | ❏ Other  please specify |
| **B3. Are you still a serving member of the ADF?** | | |

❏ **YES** ❏ **NO If NO, What year did you leave?**

**B4. In January 1991, what was your rank?**

please specify

Office use only

**INSTRUCTIONS:** *Please answer the following questions about military postings, including postings with defence forces of other countries, that you have held for* ***3 months or more.***

*Please DO NOT include postings that you held as a reservist in the military.*

**B5. Please write in the year you started each non-reserve posting, the duration of the posting in years and months, the rank mostly held for that posting, the name of your unit, ship or squadron, your category/branch, corps or mustering and a brief description of your duties, the type of area that you worked in. Then please indicate whether you regularly worked with or handled pesticides, fuels, engine exhaust, or solvents during those postings***.*

*Please start with your first posting and continue in order. If the duties were substantially the same from one posting to the next you may amalgamate the postings.*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Year**  **Started** | **Duration in years & months** | **Rank Mostly held** | **Name of Unit/Ship/ Squadron** | **Category/Branch, Corps or Mustering and a brief description of duties** | **Was it primarily?** Select the most relevant option | **Did you regularly work with or handle any of the following?**  Select all that apply |
| *Eg* | 1975 | 2 yrs  6 mo | Able seaman | HMAS Success | Seaman,  engine maintenance painting ship | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ✔ Ship below decks | ❏ Pesticides  ✔ Solvents  ✔ Fuels  ✔ Engine Exhaust  ❏ None of these |
| *1* |  | yrs  mo |  |  |  | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ❏ Ship below decks | ❏ Pesticides  ❏ Solvents  ❏ Fuels  ❏ Engine Exhaust  ❏ None of these |
| *2* |  | yrs  mo |  |  |  | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ❏ Ship below decks | ❏ Pesticides  ❏ Solvents  ❏ Fuels  ❏ Engine Exhaust  ❏ None of these |
| *3* |  | yrs  mo |  |  |  | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ❏ Ship below decks | ❏ Pesticides  ❏ Solvents  ❏ Fuels  ❏ Engine Exhaust  ❏ None of these |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Year**  **Started** | **Duration in years & months** | **Rank Mostly held** | **Name of Unit/Ship/ Squadron** | **Category/Branch, Corps or Mustering and a brief description of duties** | **Was it primarily?** Select the most relevant option | **Did you regularly work with or handle any of the following?**  Select all that apply |
| *4* |  | yrs  mo |  |  |  | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ❏ Ship below decks | ❏ Pesticides  ❏ Solvents  ❏ Fuels  ❏ Engine Exhaust  ❏ None of these |
| *5* |  | yrs  mo |  |  |  | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ❏ Ship below decks | ❏ Pesticides  ❏ Solvents  ❏ Fuels  ❏ Engine Exhaust  ❏ None of these |
| *6* |  | yrs  mo |  |  |  | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ❏ Ship below decks | ❏ Pesticides  ❏ Solvents  ❏ Fuels  ❏ Engine Exhaust  ❏ None of these |
| *7* |  | yrs  mo |  |  |  | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ❏ Ship below decks | ❏ Pesticides  ❏ Solvents  ❏ Fuels  ❏ Engine Exhaust  ❏ None of these |
| *8* |  | yrs  mo |  |  |  | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ❏ Ship below decks | ❏ Pesticides  ❏ Solvents  ❏ Fuels  ❏ Engine Exhaust  ❏ None of these |
| *9* |  | yrs  mo |  |  |  | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ❏ Ship below decks | ❏ Pesticides  ❏ Solvents  ❏ Fuels  ❏ Engine Exhaust  ❏ None of these |
| *10* |  | yrs  mo |  |  |  | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ❏ Ship below decks | ❏ Pesticides  ❏ Solvents  ❏ Fuels  ❏ Engine Exhaust  ❏ None of these |
| *11* |  | yrs  mo |  |  |  | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ❏ Ship below decks | ❏ Pesticides  ❏ Solvents  ❏ Fuels  ❏ Engine Exhaust  ❏ None of these |
| *12* |  | yrs  mo |  |  |  | ❏ Workshop  ❏ Office  ❏ Field  ❏ Barracks  ❏ Ship above deck  ❏ Ship below decks | ❏ Pesticides  ❏ Solvents  ❏ Fuels  ❏ Engine Exhaust  ❏ None of these |

*GO TO SECTION C*

IF YOU ARE A GULF WAR VETERAN, A COPY OF YOUR GULF WAR

DEPLOYMENT RECORD SHOULD BE STAPLED HERE.

***GULF WAR VETERANS ONLY SHOULD ANSWER THIS SECTION***

*If NOT a Gulf War Veteran, please go to SECTION D*

**SECTION C: YOUR DEPLOYMENT TO THE GULF WAR**

We would like to know some specific details about your deployment to the Gulf War.

*The Gulf War Nominal Roll records your service number, date entered the operational area, date departed the operational area, ship/unit/squadron, rank and corps/mustering. A copy of your Gulf War Nominal Roll record should be stapled to the previous page.*

**C1. Please check the details of the deployment record from the Nominal Roll, writing any necessary corrections clearly and directly on to the stapled sheet.**

*Please mark the box below to indicate that you have checked the attached Nominal Roll record and that you have made any needed corrections.*

❏ **I have checked my Nominal Roll deployment record and have made any needed corrections.**

**C2a. What were your primary duties during your deployment to the Gulf War?**

|  |  |
| --- | --- |
| (mark all boxes that apply)  ❏ On board a frigate or destroyer | ❏ Logistic support/staff duties |
| ❏ On board a supply ship | ❏ Medical |
| ❏ On board a submarine | ❏ Environmental health duties |

❏ Mine countermeasures ❏ Airbase support

❏ Ground Crew ❏ Airfield guarding

❏ Engaged in combat/combat missions/combat patrols

❏ Combat support/flight-line support/convoy protection

❏ Other duty

please specify

**C2b. Please write your job title, or trade, applicable to when you were there (eg technician, cook, driver)**

(job title or trade)

**C3. During your Gulf War deployment were you:**

**a. attached to ship**

❏NO ❏ YES

*If YES*, which ship? ❏ HMAS Darwin ❏ HMAS Brisbane

❏ HMAS Sydney ❏ HMAS Westralia

❏ HMAS Adelaide ❏ HMAS Success

❏ USNS Comfort

❏ Other

please specify

**b. attached to a static HQ**

❏ NO ❏ YES

*If YES, w*hich location? ❏ Australia ❏ Saudi Arabia (eg Riyadh)

❏ Bahrain ❏ UAE (eg Abu Dhabi)

❏ Iraq ❏ Oman (eg Muscat)

❏ Other

please specify

**c. did you serve as part of Operation Habitat?**

❏ NO ❏ YES

**d. were you attached to a manoeuvre HQ?**

❏ NO ❏ YES

If YES, Where was the start deployment? Where was the finish deployment?

**C4. During your deployment to the Gulf on how many days did you have direct contact with, or were you exposed to, intense smoke from burning oil wells?**

❏ None ❏ 1-3 days ❏ 4-9 days ❏ 10-30 days ❏ more than 30 days ❏ Don't know

*IF 1 day or more*

**b. During the smoke and oil cloud, for how many hours on each of those days, on average, were you outside/on the upper decks?**

❏ <1 hour ❏ 1-4 hours ❏ 5-8 hours ❏ >8 hours

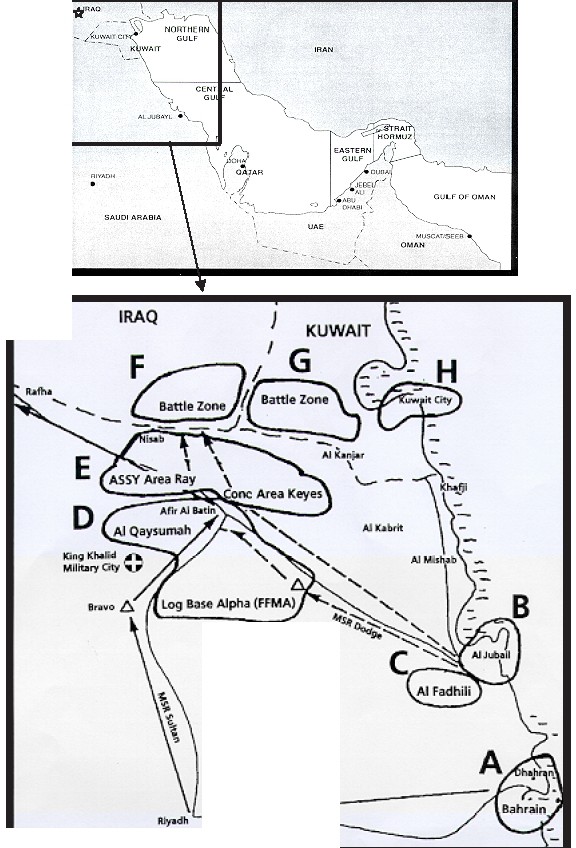
**C5. During your deployment to the Gulf War did you serve, or at any time visit or set foot, on land in any of the countries surrounding the Persian Gulf waters (such as Saudi Arabia, Kuwait, Iraq, Iran etc)?**

❏ NEVER ❏ YES

**If YES please look at maps and answer question C6 on the next pages**

**If NEVER** *please go to QUESTION C7*

*Question C6. Use this map and the enlargement below to identHy where you were on land in any of the countTies surrounding the Persian Gulf waters*



**SAUDI ARABIA**

*This map shows the main areas where* ***ground forces*** *were located. Several areas are listed on the map with a code (A to H). Please note that the location code includes the whole of the area circled.*

***Question C6 continued***

|  |  |  |  |
| --- | --- | --- | --- |
| *Location Code* | *Examples* | *Location Code* | *Examples* |
| *A* | *Dahran, Bahrain* | *B* | *Al Jubail,*  *e.g. Baldrick Lines* |
| *C* | *Devil Dog Dragoon Range,*  *Al Fadhili, St. Patrick's Camp*  *Jerboa Range* | *D* | *Al Qaysyumah,*  *Log Base Alpha (FFMA), Hafar Al Batin* |
| *E* | *Ex. Dibdibah Range or Charge Concentration Milton Keynes, Assemble Area Ray* | *F* | *Southern Iraq Battle Zone*  *e.g. Bronze, Lead, Tungsten, Copper, Cobalt, Varsity* |
| *G* | *Kuwait (excluding Kuwait City)* | *H* | *Kuwait City* |

**C6a. Please indicate in the table, at the bottom of the page, which ground locations you served at or visited during your Gulf War deployment and indicate when you were there. Please use the codes provided on the map OR, if you went to a location not coded on**

**the map, please give its name.**

Nb. The Aerial Bombardment commenced on 17th January 1991. The Main Battle took place in Areas F

and G between 24th and 28th February 1991.

*The example provided is for a veteran whose Gulf War deployment took him/her first to Al Jubail (Area B) between January 17 and February 28, subsequently to Bahrain (Area A) after February 28, and finally to Karachi (not coded on the map) also after February 28.*

**Example only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Location | Before war was declared  (pre Jan 17) | During the war  (Jan 17–Feb 28) | After the cease-fire  (post Feb 28) |
| **1st location** | B | ❏ | ✔ | ❏ |
| **2nd location** | A | ❏ | ❏ | ✔ |
| **3rd location** | Karachi | ❏ | ❏ | ✔ |

**Which ground locations did you serve at or visit?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Location | Before war was declared  (pre Jan 17) | During the war  (Jan 17–Feb 28) | After the cease-fire  (post Feb 28) |
| **1st location** |  | ❏ | ❏ | ❏ |
| **2nd location** |  | ❏ | ❏ | ❏ |
| **3rd location** |  | ❏ | ❏ | ❏ |
| **4th location** |  | ❏ | ❏ | ❏ |
| **5th location** |  | ❏ | ❏ | ❏ |
| **6th location** |  | ❏ | ❏ | ❏ |
| **7th location** |  | ❏ | ❏ | ❏ |

**C6b. Were you near Khamisiayah in southern Iraq (**✩**on the top map) in March 1991?**

❏ NO ❏ YES

C, GULF WAR DEPLOYMENT

C6c. Were you at camp Doha on July 11'", when the North Compound caught fire, or involved in the subsequent clean up operations?

0 NO DYES

GO *TO Question* C7

**Section C continued VACCINATIONS & MEDICATIONS**

*We would like to know about vaccinations and medications you received as part of your deployment to the Gulf War.*

*If you have a written record of these vaccinations, e.g. your WHO International Certificates of Vaccination 'yellow book', please refer to it when completing this section; and bring the book with you to the medical examination. If you do not have your 'yellow book', please indicate this, but still complete this section to the best of your ability.*

**C7. Do you have your WHO 'yellow book' to refer to?** ❏ YES ❏ NO

**C8. As part of your Gulf War deployment, how many vaccinations did you receive:**

**before you left** for the Gulf? ❏ none ❏ 1 ❏ 2 ❏ 3 ❏ 4 ❏ 5 ❏ 6 ❏ >7 ❏ Don't know

**Over what time period did you receive these?**

❏ all in one session ❏ across 1 week ❏ across 2-4 weeks ❏ across a period > 4 weeks

**in transit to** the Gulf? ❏ none ❏ 1 ❏ 2 ❏ 3 ❏ 4 ❏ 5 ❏ 6 ❏ >7 ❏ Don't know

**Over what time period did you receive these?**

❏ all in one session ❏ across 1 week ❏ across 2-4 weeks ❏ across a period > 4 weeks

**while you were in** the Gulf? ❏ none ❏ 1 ❏ 2 ❏ 3 ❏ 4 ❏ 5 ❏ 6 ❏ >7 ❏ Don't know

**Over what time period did you receive these?**

❏ all in one session ❏ across 1 week ❏ across 2-4 weeks ❏ across a period > 4 weeks

**C9. Which of the following vaccinations do you think you received:**

|  |  |  |  |
| --- | --- | --- | --- |
| Typhoid | ❏ No | ❏ Yes | ❏ Don't know |
| Cholera | ❏ No | ❏ Yes | ❏ Don't know |
| Diptheria, Tetanus (ADT) | ❏ No | ❏ Yes | ❏ Don't know |
| Pertussis (whooping cough) | ❏ No | ❏ Yes | ❏ Don't know |
| Hepatitis B | ❏ No | ❏ Yes | ❏ Don't know |
| Measles, Mumps, Rubella (MMR) | ❏ No | ❏ Yes | ❏ Don't know |
| Polio (oral Sabin) | ❏ No | ❏ Yes | ❏ Don't know |
| Tuberculosis (BCG) | ❏ No | ❏ Yes | ❏ Don't know |
| Hepatitis A (Havrix) | ❏ No | ❏ Yes | ❏ Don't know |
| Smallpox | ❏ No | ❏ Yes | ❏ Don't know |
| Anthrax | ❏ No | ❏ Yes | ❏ Don't know |
| Plague | ❏ No | ❏ Yes | ❏ Don't know |
| Other | ❏ No | ❏ Yes | ❏ Don't know |

If Other, please specify

**C10. Did you take anti-nerve agent pills (i.e. PB or NAPS)?**

❏ **NO** ❏ **YES** ❏ **Don't know**

**If YES,**

**a. Please estimate how many days you took them for in total?**

**b. On average how many did you take each day?**

❏ 1 ❏ 2 ❏ 3 ❏ >3 ❏ Don't know

\_ \_ \_ days

**C11. Did you take tablets to protect you against malaria (e.g. chloroquine or doxycycline)?**

❏ **NO** ❏ **YES** ❏ **Don't know**

**If YES,**

**a. please estimate how many days you took them for in total?**

\_ \_ \_ days

**C12. Did you take any anti-biological warfare tablets (Ciprofloxacin or ì Ciproxinî )?**

❏ **NO** ❏ **YES** ❏ **Don't know**

**If YES,**

**a. please estimate how many days you took them for in total?** \_ \_ \_ days

**C13. Did you have a significant reaction to any vaccinations or medications that you received?**

❏ **NO** ❏ **YES**

**If YES,**

**a. Please specify which vaccination(s) or medication(s) you reacted to**

**b. Which vaccination or medication resulted in the most severe reaction.**

Please specify one

**c. How long did this most severe reaction last?**

\_ \_ \_ days

**d. Did you need to seek medical advice for this reaction**

❏ **NO** ❏ **YES**

*GO TO SECTION D.*

**SECTION D: DEPLOYMENTS** *(Everyone should answer this section)*

**D1a. Have you been on an active deployment (war or peacekeeping). This does not include training exercises or goodwill visits**

**(flying the flag).**

❏ **YES** GO TO QUESTION D1b. ❏ **NO** GO TO SECTION E

**D1b. In the table below please indicate where you were actively deployed. Remember that this does not include training exercises or goodwill visits (flying the flag).**

**INSTRUCTIONS:** *From this list please mark the YES box for those active deployments which apply to you. Then, please write the year in which you were deployed, the approximate duration of your participation in that deployment and indicate whether you were ordered to serve on that deployment or whether you volunteered*.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Were you deployed to:** | **Yes** | **Year First Deployed** | **Duration** (Choose the nearest period)  (If you went more than once show the total time)  **Less than one One week to less One month to less More than 6 week than one month than 6 months months** | | | | **Were you ordered to serve or did you volunteer to serve?**  **Ordered Volunteered** |
| 1. Angola | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 2. Afghanistan | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 3. Balkanís | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 4. Bougainville 1997 → | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 5. Cambodia 1993 -1999 | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 6. East Timor 1999 → | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 7. Egypt | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 8. Former Rep of Yugoslavia 1997 → | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 9. Gulf of Oman 1999 | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 10. Korea 1953 → | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 11. Kuwait 1998 → | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 12. Malaysia | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |

**D1. continued**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | **Were you deployed to:** | **Yes** | **Year**  **Deployed** | **Duration (Choose the nearest period)**  **Less than one One week to less One month to less More than 6 week than one month than 6 months months** | | | | **Were you ordered to serve or did you volunteer to serve?**  **Ordered Volunteered** |
| 13. Middle East 1956 → | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 14. Mozambique 1994 → | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 15. Namibia 1989-1990 | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 16. Papua New Guinea 1997-1998 | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| Gulf War Vets |  |  |
| 17. Persian Gulf (between 2/8/90 & 4/9/91) | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
|  |  |
| 18. Persian Gulf (not between 2/8/90 &  4/9/91) | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
|  | | |
| 19. Rwanda | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 20. Sinai 1982-1986 & Sinai 1993 → | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 21. Solomon Islands | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 22. Somalia 1994 | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 23. Southern Ocean | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 24. Thailand | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 25. Vietnam | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 26. Western Sahara | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |

***Any other deployments overseas, please specify destination/s below.*** *Do* ***not*** *include training exercises or goodwill visits (flying the flag).*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 27. | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 28. | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 29. | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |
| 30. | ❏ | \_ \_ \_ \_ | ❏ | ❏ | ❏ | ❏ | ❏ ❏ |

*If you answered NO to question D1a (no active deployments) please GO TO Section E*

**CHEMICAL & ENVIRONMENTAL EXPOSURES**

**D2.** We would like to know about chemical or environmental contaminants that you may have been exposed to during the deployments you listed in Question D1.

**INSTRUCTIONS:** *Please indicate whether or not you have experienced any of the activities and items, given below, during the deployments you listed at question D1. If YES, indicate whether it was experienced during your non-Gulf War deployments (section labeled 'Everyone'), and/or during your Gulf War deployment (section labeled 'GW Vets only'). Then estimate, for each section, how often you had the experience.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **D2.** | *Everyone*  ***during non-Gulf War deployments*** | | | *GW Vets only*  ***during the Gulf War deployment*** | | |
| **During the deployments you listed in question D1:** | **NO** | **DON'T KNOW** | YES | **NO** | **DON'T KNOW** | YES |
| **How often? Rarely Some Often times** | **How often? Rarely Some Often times** |
| 1. Have you entered, or inspected, captured or destroyed enemy equipment including tanks? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 2. Have you been in contact with depleted uranium shell casings? (e.g. from **fired USA** shells in close-in weapons systems (CIWS) or **spent** anti-tank shells) | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 3. Have you been in contact with wet CARC paint (Chemical Agent Resistive Coating) from freshly painted tracked vehicles or CARC paint containers? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 4. On overseas operations/activities have you eaten locally sourced, **military issue** food? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 5. On overseas operations/activities have you eaten locally sourced, **non-military issue** food? e.g. from local villagers. | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 6. On overseas operations/activities have you drunk water from local taps or wells? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 7. Have you drunk water that looked or tasted like it had oil in it? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 8. On overseas operations/activities have you swum or bathed in local lakes, rivers or the sea? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 9. Have you showered in water with fuel in it  (evident by visible oil film, smell or smarting eyes)? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 10. Were you exposed to dust storms? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 11. Were you exposed to intense smoke? e.g. from forest fires or burning oil | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 12. Did you do any refuelling? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 13. Were you exposed to solvents? e.g. from cleaning or painting | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 14. Have you had solvents, oils, diesel or other fuel on your skin? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 15. Have you been exposed to engine exhaust so that it irritated your eyes? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 16. Did you use a sunscreen when outdoors? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 17. Have you been bitten by flies, sand flies, fleas, mosquitoes or other insects? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 18. Have you been stung or bitten by spiders, scorpions or other "bugs"? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 19. Have you worn a flea collar? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 20. Were your clothing or uniforms treated with pesticides? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 21. Was your tent treated with pesticides? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 22. Was your sleeping bag treated with pesticides? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 23. Did you live or work an area that had been recently sprayed or fogged with a pesticide? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **D3.** | *Everyone*  ***during non-Gulf War deployments*** | | | *GW Vets only*  ***during the Gulf War deployment*** | | |
| **During the deployments you listed in Question D1:** | **NO** | **DON'T KNOW** | YES | **NO** | **DON'T KNOW** | YES |
| **How often were you there? Rarely Sometimes Often** | **How often were you there? Rarely Sometimes Often** |
| a. Were you in an area where chemical warfare agents had probably been used? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |

*If No or Don't Know go to*

|  |  |
| --- | --- |
| **What chemical agents had been used?**  ❏ Nerve gas  ❏ Mustard gas  ❏ Other unknown  ❏ Other  please specify | **What chemical agents had been used?**  ❏ Nerve gas  ❏ Mustard gas  ❏ Other unknown  ❏ Other  please specify |
| **What made you think that chemical warfare agents had been used?**  ❏ I felt ill at the time  ❏ Saw dead or affected animals  ❏ Saw dead or affected people  ❏ Chemical alarms went off  ❏ I was told so  ❏ Another reason,  please specify | **What made you think that chemical warfare agents had been used?**  ❏ I felt ill at the time  ❏ Saw dead or affected animals  ❏ Saw dead or affected people  ❏ Chemical alarms went off  ❏ I was told so  ❏ Another reason,  please specify |

*D4*.

*If YES, (tick all that apply below) If YES, (tick all that apply below)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **D4.** | *Everyone*  ***during non-Gulf War deployments*** | | |  | *GW Vets only*  ***during the Gulf War deployment*** | |
|  |  |  | YES |  |  | YES |
| **During the deployments you listed in Question D1:** | **NO** | **DON'T KNOW** | **How often did you use it? Rarely Sometimes Often** | **NO** | **DON'T KNOW** | **How often did you use it? Rarely Sometimes Often** |
| a. Did you use a respirator? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |

*If YES, (tick all that apply below) If YES, (tick all that apply below)*

**Why did you use a respirator? Why did you use a respirator?**

*If No or Don't Know go to*

*D5.*

❏ Dust storms

❏ Smoke from oil well fires

❏ Chemical alarms

❏ Biological alarms

❏ Smoke forest fires

❏ Another reason,

❏ Dust storms

❏ Smoke from oil well fires

❏ Chemical alarms

❏ Biological alarms

❏ Smoke forest fires

❏ Another reason,

please specify

please specify

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **D5.** | *Everyone*  ***during non-Gulf War deployments*** | | | *GW Vets only*  ***during the Gulf War deployment*** | | |
| **During the deployments you listed in Question D1:** | **NO** | **DON'T KNOW** | YES | **NO** | **DON'T KNOW** | YES |
| **How often did you use it? Rarely Sometimes Often** | **How often did you use it? Rarely Sometimes Often** |
| a. Did you use a chemical protective suit (NBC suit)? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |

*If No or Don't Know go to*

*D6.*

*If YES, (tick all that apply below) If YES, (tick all that apply below)*

**Why did you use an NBC suit? Why did you use an NBC suit?**

❏ Dust storms ❏ Dust storms

❏ Smoke ❏ Smoke

❏ Chemical alarms ❏ Chemical alarms

❏ Biological alarms ❏ Biological alarms

❏ Another reason, ❏ Another reason,

please specify please specify

**D6. a. During the deployments you listed in Question D1, were you ever issued with a personal insect repellant?**

❏ NO ❏ YES

**If YES please fill in the following table indicating which type of repellant and how often you used it.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | *Everyone*  ***during non-Gulf War deployments*** | | | *GW Vets only*  ***during the Gulf War deployment*** | | |
| **What was the personal insect repellant?** | **NO** | **DON'T KNOW** | YES | **NO** | **DON'T KNOW** | YES |
| **How often did you use it? Rarely Sometimes Often** | **How often did you use it? Rarely Sometimes Often** |
| 1. Repellant MK1941, lotion, gel or cream | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 2. Repellant sachet | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 3. Miticide (DBP) | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 4. Other (please name it) |  | | ❏ ❏ ❏ |  | | ❏ ❏ ❏ |

**b. During the deployments you listed in Question D1, did you provide and use your own personal insect repellant (ie. non-military issue)**

❏ NO ❏ YES

**If YES please fill in the following table indicating which type of repellant and how often you used it.**

|  |  |  |
| --- | --- | --- |
|  | *Everyone*  ***during non-Gulf War deployments*** | *GW Vets only*  ***during the Gulf War deployment*** |
| **What was the personal insect repellant?** | **How often did you use it?**  rarely sometimes often | **How often did you use it?**  rarely sometimes often |
| Please name it | ❏ ❏ ❏ | ❏ ❏ ❏ |

**D7. During the deployments you listed in Question D1, did you ever apply pesticides including insecticides (but not including personal repellants) e.g. by spraying, fogging, laying bait etc?**

❏ NO ❏ YES

**If Yes, was it? (mark all those that apply)**

|  |  |  |
| --- | --- | --- |
| ❏ Permethrin based | ❏ Baygon (Propoxur, Aprocarb) | ❏ Bendicarb (Ficam) |
| ❏ Diazinon | ❏ Temephos (Abate) | ❏ Malathion (Maldison) |
| ❏ Other, unknown type | ❏ Other, called | |
| please specify | | |

**And please complete the following table about applying pesticides.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **D8.** | *Everyone*  ***during non-Gulf War deployments*** | | | *GW Vets only*  ***during the Gulf War deployment*** | | |
| **Did you ever?** | **NO** | **DON'T**  **KNOW** | YES | **NO** | **DON'T KNOW** | YES |
| **How often did you use it? Rarely Sometimes Often** | **How often did you use it? Rarely Sometimes Often** |
| 1. Spray/fog an outdoor area e.g. for mosquitoes | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 2. Spray/fog an indoor area e.g. for cockroaches | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 3. Spray your body (with pesticides, not personal repellants) | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 4. Spray your uniform or bedding? | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |
| 5. Lay bait as a solid or liquid e.g. rat poison | ❏ | ❏ | ❏ ❏ ❏ | ❏ | ❏ | ❏ ❏ ❏ |

*GO TO QUESTION D9*

**POST DEPLOYMENT EXPERIENCES**

**D9**. We would like to know about some of the experiences you may have had after returning from the deployments you told us about in question D1.

*If you answered NO to question D1.a (no active deployments) please GO TO Section E*

**INSTRUCTIONS**: *Please indicate whether you have experienced any of the items listed below, as a result of having served in the deployments you listed at question D1. If YES, indicate whether it was related to non-Gulf War deployments (section labeled 'Everyone'), and/or during your Gulf War deployment (section labelled 'Gulf War Vets only'). Then estimate, for each section, whether you experienced the item a little, somewhat or a lot.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | *Everyone*  ***After returning from non-Gulf***  ***War deployments*** | | *GW Vets only*  ***After returning from the Gulf***  ***War deployment*** | |
| **As a result of having served in deployments listed in question D1, have you experienced, or felt, any of the following?** | **NO** | **YES** | **NO** | **YES** |
| **How much?**  **A little Some A lot** | **How much?**  **A little Some A lot** |
| 1. Greater self-pride? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 2. Rewarded for a job well done? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 3. A greater appreciation for your country? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 4. Jealousy or resentfulness from other  Defence Force members? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 5. Lack of recognition, or acknowledgement, of the value or nature of your deployment activities by the ADF or by the Australian Government? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 6. Inadequately debriefed following your deployment activities? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 7. Improved as a leader? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 8. Tougher, more confident or more self assured? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 9. More knowledgeable of world issues? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 10. Disillusioned by the destruction or hopelessness that you witnessed? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 11. Valued and respected for your deployment activities? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 12. Lack of recognition, or acknowledgement, of the value or nature of your deployment activities by the Australian people? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 13. More appreciative of being alive? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 14. More respectful of other Australian and allied veterans? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 15. Well looked after by the ADF or the  Australian Government? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 16. Stronger bonds with the members of your ship/unit/squadron | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |
| 17. Proud to be an Australian veteran? | ❏ | ❏ ❏ ❏ | ❏ | ❏ ❏ ❏ |

*GO TO SECTION E*

**SECTION E: MILITARY SERVICE EXPOSURES** *(Everyone should answer this section)*

**E1.** We would like to know about some of your experiences, during your **ENTIRE** military service, especially those experiences which may have been stressful or upsetting.

**INSTRUCTIONS:** *Please indicate whether or not you were in contact with, or experienced, any of the items listed below, as part of your military service. If YES, indicate whether it was experienced during non-Gulf War service (section labeled 'Everyone'), and/or during your Gulf War service (section labeled 'GW Vets only'). Then estimate, for each section, how frequently you had the experience, and whether the experience made you feel unwell, stressed or uneasy.*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | *Everyone*  ***during non-Gulf War service*** | | | | | *GW Vets only*  ***during the Gulf War service*** | | | | |
| **As part of your military service have you been in contact with, or have you experienced,**  **any of the following?** | **NO** | **YES** | **AND did this experience make you feel unwell, stressed or uneasy?** | | | **NO** | **YES** | **AND did this experience make you feel unwell, stressed or uneasy?** | | |
| **How often?**  **Rarely Sometimes Often** | **No** | **YES**  **mildly** | **YES**  **strongly** | **How often?**  **Rarely Sometimes Often** | **NO** | **YES**  **mildly** | **YES**  **strongly** |
| 1. You were on a ship which suffered a collision or was otherwise damaged or sunk during deployment. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 2. Artillery, rockets, missiles, mines or something similar, exploded in the air, in the water or on the ground close to you. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 3. You saw Defence personnel or civilians who were killed, dead, dying or maimed. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 4. You made a leadership decision which you think resulted in the death or injury of someone. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 5. You have suffered ill-effects of extreme heat or extreme cold. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 6. You had to eat food or drink water contaminated with smoke, oil, sewerage or other chemical or biological  agents. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 7. You had to work, dive or bathe in water contaminated with smoke, oil, sewerage or other chemical or biological  agents. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 8. Operational rules of engagement prevented you from taking action which could protect you or others from harm. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 9. You experienced lack of leadership in your team, crew or unit. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 10. You came under small arms fire. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 11. You handled, buried or exhumed human bodies. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***E1. continued*** | *Everyone*  ***during non-Gulf War service*** | | | | | *GW Vets only*  ***during the Gulf War service*** | | | | |
| **As part of your military service have you been in contact with, or have you experienced,**  **any of the following?** | **NO** | **YES** | **AND did this experience make you feel unwell, stressed or uneasy?** | | | **NO** | **YES** | **AND did this experience make you feel unwell, stressed or uneasy?** | | |
| **How often?**  **Rarely Sometimes Often** | **No** | **YES**  **mildly** | **YES**  **strongly** | **How often?**  **Rarely Sometimes Often** | **NO** | **YES**  **mildly** | **YES**  **strongly** |
| 12. You encountered undetonated mines, including sea mines*,*  or booby traps while on patrol or at your duty station. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 13. You killed someone or think you might have killed someone. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 14. Your supplies or equipment were inadequate, insufficient or faulty. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 15. You were deployed to a combat situation against your will. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 16. You were attacked by civilians, bandits or other local militia groups. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 17. You were sexually harassed. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 18. You were responsible for detecting incoming attacks or for spotting land or sea-mines, where a mistake could place  the lives of others at risk. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 19. You were required to administer medical for which you were not adequately trained or equipped, eg. geriatrics,  pediatrics, palliative care. *(Answer NO if not applicable*) | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 20. You experienced a 'near miss' or 'very close call' incident where you were in iminent danger of being injured or killed. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 21. You were required to detonate, deactivate or otherwise handle live missiles, mines, bombs or other explosive devices. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 22. You handled or came into contact with POWs or displaced refugees. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 23. You had to board hostile vessels at sea. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 24. You had to decide who would receive life-saving medical care. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 25. You felt an overwhelming inability to protect yourself or others from harm. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 26. You were in fear for your life. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***E1. continued*** | *Everyone*  ***during non-Gulf War service*** | | | | | *GW Vets only*  ***during the Gulf War service*** | | | | |
| **As part of your military service have you been in contact with, or have you experienced,**  **any of the following?** | **NO** | **YES** | **AND did this experience make you feel unwell, stressed or uneasy?** | | | **NO** | **YES** | **AND did this experience make you feel unwell, stressed or uneasy?** | | |
| **How often?**  **Rarely Sometimes Often** | **No** | **YES**  **mildly** | **YES**  **strongly** | **How often?**  **Rarely Sometimes Often** | **NO** | **YES**  **mildly** | **YES**  **strongly** |
| 27. You felt not sufficiently trained or prepared for military activities. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 28. You felt lack of togetherness or cohesion in your team or unit. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 29. You suffered burns or rashes on your skin as a result of exposure to oil or other chemicals in the air. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 30. You witnessed violent attacks on civilians including rape or other assaults. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 31. You were on formal alert for, or felt in threat of nuclear, biological or chemical agent attack. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 32. You were exposed to nuclear, biological or chemical warfare. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 33. You felt cut off or separated from family or significant others. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 34. You were on a ship or aircraft (including a helicopter)  passing through hostile waters or air space. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 35. You sat with or cared for someone who was dying. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 36. You were in fear of artillery, missile, SCUD rocket or bomb attack. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 37. You had difficulty breathing as a result of exposure to oil, smoke, fumes, dust or other contaminants in the air. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 38. You carried out your duties wearing NBC suits (not including training exercises). | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 39. You felt alienated from other military personnel around you. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 40. You felt overwhelmed by the level of destruction or devastation or disease around you. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 41. On board a ship you feared death, injury or entrapment below the waterline as a result of missile attack or hitting a  sea-mine. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 42. You were required to live in squalid, unsanitary or disease- ridden conditions. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 43. You feared attack from bandits, rebels or other local militia groups. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |
| 44. You sustained an injury that required medical treatment. | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | | ❏ | ❏ ❏ ❏ | ❏ ❏ ❏ | | |

**SECTION F: CIVILIAN OCCUPATIONAL HISTORY** *(Everyone should answer this section)*

**F1. Have you ever been a CFA Volunteer?** ❏ **NO** ❏ **YES If YES, for how long** ❏ <1 year ❏ 1-5 years ❏ 6-10 years ❏ >10 years

**F2. Have you held any civilian jobs for more than 6 months?** ❏ **YES** *GO TO Question F3* ❏ **NO** *PLEASE GO TO SECTION G*

**F3. For every civilian job that you have held for six months or more, please complete the table below. Please start with your first civilian job and add new jobs in order.** Please write in the year you started each civilian job, your job title, the duration of the job in years and months, the Industry, and the name of the Company or employer. Then indicate whether, as part of that job, you handled, worked with or were otherwise exposed to pesticides, fuels, engine exhaust, or solvents, and whether that job involved exposure to infectious diseases or trauma to others (such as violence, grief or death of others). An example is provided for you.

*It may be useful to refer to your personal records, such as an old copy of a resume, to remind you about jobs which you may have forgotten.*

**Year**

**Duration**

**Job Title Industry Sector Company/Employer**

**This job exposed me to:**

**Office**

**Started**

**in years &**

**months**

**Pesticides Fuels Engine**

**Exhaust**

**Solvents Infectious diseases**

**Trauma**

**Only**

e.g 1975 4 yrs

4 mo

Painter Construction Self-employed ❏ Yes

√ No

❏ Yes

√ No

❏ Yes

√ No

√ Yes

❏ No

❏ Yes

√ No

❏ Yes

√ No

1 yrs

mo

2 yrs

mo

3 yrs

mo

4 yrs

mo

5 yrs

mo

6 yrs

mo

7 yrs

mo

8 yrs

mo

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

**Year**

**Duration**

**Job Title Industry Sector Company/Employer This job exposed me to: Office**

**Started**

**in years &**

**months**

**Pesticides Fuels Engine**

**Exhaust**

**Solvents Infectious diseases**

**Trauma**

**Only**

9 yrs

mo

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

10 yrs

mo

11 yrs

mo

12 yrs

mo

13 yrs

mo

14 yrs

mo

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

❏ Yes

❏ No

*If you answered YES to pesticide exposure in the Table at F3, please answer question F4. If NO to pesticide exposure GO TO SECTION G.*

**F4. Please list the job number from the table at F3, the pesticides which you were exposed to and tell us the activity that led to exposure.**

|  |  |  |
| --- | --- | --- |
| **Job Number** | **Pesticide** | **Activity leading to Exposure** |
| e.g. 4 | Sheep dip, (Organophosphate type) | Mixing dip, Dipping sheep |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Well done - you are half way there!**

**Keep up the good work.**

**Remember, the Study team is available on** 1800 062 534 **if you are unsure about how to complete any section of this questionnaire. Please call any time Monday to Friday during business hours.**

**SECTION G: YOUR HEALTH IN GENERAL** *(Everyone should answer this section)*

**G1. In general, would you say your health is:**

❏ Excellent ❏ Very good ❏ Good ❏ Fair ❏ Poor

**G2. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

|  |  |  |
| --- | --- | --- |
| **Yes,** | **Yes,** | **No, Not** |
| **Limited** | **Limited** | **Limited** |
| **a Lot** | **a Little** | **at All** |

a. **Moderate activities**, such as moving a table, ❏ ❏ ❏

pushing a vacuum cleaner, bowling, or playing golf

b. Climbing **several** flights of stairs ❏ ❏ ❏

**G3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

|  |  |  |
| --- | --- | --- |
| a. **Accomplished less** than you would like | ❏ YES | ❏ NO |
| b. Were limited in the **kind** of work or other activities | ❏ YES | ❏ NO |

**G4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

a. **Accomplished less** than you would like ❏ YES ❏ NO

b. Didn't do work or other activities as **carefully** as usual ❏ YES ❏ NO

**G5. During the past 4 weeks, how much did pain interfere with your normal work**

**(including both work outside the home and housework)?**

❏ Not at all ❏ A little bit ❏ Moderately ❏ Quite a bit ❏ Extremely

**G6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.**

**How much of the time during the past 4 weeks.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **All of the**  **Time** | **Most of the Time** | **A Good**  **Bit of the Time** | **Some of the Time** | **A Little of the Time** | **None of the Time** |

a. Have you felt calm and ❏ ❏ ❏ ❏ ❏ ❏

peaceful?

b. Did you have a lot of ❏ ❏ ❏ ❏ ❏ ❏

energy?

c. Have you felt ❏ ❏ ❏ ❏ ❏ ❏

downhearted and blue?

**G7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ❏ All of the | ❏ | Most of the | ❏ | Some of the | ❏ | A little of the | ❏ None of the |
| Time |  | Time |  | Time |  | Time | Time |

**SECTION G: YOUR HEALTH IN GENERAL continued**

We would like to know how you have been feeling **over the past few weeks**.

*Please tick the box that most closely describes your experience for each question*

**G8. Have you recently been able to concentrate on whatever you're doing?**

❏ Better than usual ❏ Same as usual ❏ Less than usual

**G9. Have you recently lost much sleep over worry?**

❏ Not at all ❏ No more than usual ❏ Rather more than usual

**G10. Have you recently felt that you are playing a useful part in things?**

❏ More so than usual ❏ Same as usual ❏ Less useful than usual

**G11. Have you recently felt capable of making decisions about things?**

❏ More so than usual ❏ Same as usual ❏ Less so than usual

**G12. Have you recently felt constantly under strain?**

❏ Not at all ❏ No more than usual ❏ Rather more than usual

**G13. Have you recently felt you couldnít overcome your difficulties?**

❏ Not at all ❏ No more than usual ❏ Rather more than usual

❏ Much less than usual

❏ Much more than usual

❏ Much less useful

❏ Much less capable

❏ Much more than usual

❏ Much more than usual

**G14. Have you recently been able to enjoy your normal day-to-day activities?**

❏ More so than usual ❏ Same as usual ❏ Less so than usual

**G15. Have you recently been able to face up to your problems?**

❏ More so than usual ❏ Same as usual ❏ Less able than usual

**G16. Have you recently been feeling unhappy and depressed?**

❏ Not at all ❏ No more than usual ❏ Rather more than usual

**G17. Have you recently been losing confidence in yourself?**

❏ Not at all ❏ No more than usual ❏ Rather more than usual

❏ Much less than usual

❏ Much less able

❏ Much more than usual

❏ Much more than usual

|  |  |
| --- | --- |
| **G18.** | **Have you recently been thinking of yourself as a worthless person?**  ❏ Not at all ❏ No more than usual ❏ Rather more than usual ❏ Much more than usual |
| **G19.** | **Have you recently been feeling reasonable happy, all things considered?**  ❏ More so than usual ❏ About same as usual ❏ Less so than usual ❏ Much less than usual |

**G20. RECENT HEALTH SYMPTOMS**

We would like to know about your health in the **PAST MONTH**.

*Please indicate whether or not you have suffered any of the following symptoms in the PAST MONTH, and if so, please indicate whether your symptoms were mild, moderate or severe in nature.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **In the past month have you suffered from** | **NO Not at all** | **YES**  **Mild Moderate Severe** | | |
| 1. Chest pain | ❏ | ❏ | ❏ | ❏ |
| 2. Headaches | ❏ | ❏ | ❏ | ❏ |
| 3. Rapid or pounding heart beat | ❏ | ❏ | ❏ | ❏ |
| 4. Irritability / outbursts of anger | ❏ | ❏ | ❏ | ❏ |
| 5. Shortness of breath | ❏ | ❏ | ❏ | ❏ |
| 6. Wheezing | ❏ | ❏ | ❏ | ❏ |
| 7. Sleeping difficulties | ❏ | ❏ | ❏ | ❏ |
| 8. Feeling jumpy / easily startled | ❏ | ❏ | ❏ | ❏ |
| 9. Feeling unrefreshed after sleep | ❏ | ❏ | ❏ | ❏ |
| 10. Fatigue | ❏ | ❏ | ❏ | ❏ |
| 11. Double vision | ❏ | ❏ | ❏ | ❏ |
| 12. Intolerance to alcohol | ❏ | ❏ | ❏ | ❏ |
| 13. Itchy or painful eyes | ❏ | ❏ | ❏ | ❏ |
| 14. Rash or skin irritation | ❏ | ❏ | ❏ | ❏ |
| 15. Skin infections e.g. boils | ❏ | ❏ | ❏ | ❏ |
| 16. Skin ulcers | ❏ | ❏ | ❏ | ❏ |
| 17. Shaking | ❏ | ❏ | ❏ | ❏ |
| 18. Tingling or burning sensation in hands or feet | ❏ | ❏ | ❏ | ❏ |
| 19. Loss of sensation in hands or feet | ❏ | ❏ | ❏ | ❏ |
| 20. Feeling distant or cut off from others | ❏ | ❏ | ❏ | ❏ |
| 21. Constipation | ❏ | ❏ | ❏ | ❏ |
| 22. Flatulence or burping | ❏ | ❏ | ❏ | ❏ |
| 23. Stomach cramps | ❏ | ❏ | ❏ | ❏ |
| 24. Diarrhoea | ❏ | ❏ | ❏ | ❏ |
| 25. Indigestion | ❏ | ❏ | ❏ | ❏ |
| 26. Dry mouth | ❏ | ❏ | ❏ | ❏ |
| 27. Mouth ulcers | ❏ | ❏ | ❏ | ❏ |
| 28. Toothache | ❏ | ❏ | ❏ | ❏ |
| 29. Persistent cough | ❏ | ❏ | ❏ | ❏ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **In the past month have you suffered from** | **NO Not at all** | **YES**  **Mild Moderate Severe** | | |
| 30. Lump in throat | ❏ | ❏ | ❏ | ❏ |
| 31. Sore throat | ❏ | ❏ | ❏ | ❏ |
| 32. Forgetfulness | ❏ | ❏ | ❏ | ❏ |
| 33. Dizziness, fainting or blackouts | ❏ | ❏ | ❏ | ❏ |
| 34. Seizures or convulsions | ❏ | ❏ | ❏ | ❏ |
| 35. Feeling disorientated | ❏ | ❏ | ❏ | ❏ |
| 36. Loss of concentration | ❏ | ❏ | ❏ | ❏ |
| 37. Difficulty finding the right word | ❏ | ❏ | ❏ | ❏ |
| 38. Pain on passing urine | ❏ | ❏ | ❏ | ❏ |
| 39. Passing urine more often | ❏ | ❏ | ❏ | ❏ |
| 40. Loss of control over bladder or bowels | ❏ | ❏ | ❏ | ❏ |
| 41. Burning sensation in the sex organs | ❏ | ❏ | ❏ | ❏ |
| 42. Loss of interest in sex | ❏ | ❏ | ❏ | ❏ |
| 43. Problems with sexual functioning | ❏ | ❏ | ❏ | ❏ |
| 44. Increased sensitivity to noise | ❏ | ❏ | ❏ | ❏ |
| 45. Increased sensitivity to light | ❏ | ❏ | ❏ | ❏ |
| 46. Increased sensitivity to smells or odours | ❏ | ❏ | ❏ | ❏ |
| 47. Ringing in the ears | ❏ | ❏ | ❏ | ❏ |
| 48. Avoiding doing things or situations | ❏ | ❏ | ❏ | ❏ |
| 49. Pain, without swelling or redness, in several joints | ❏ | ❏ | ❏ | ❏ |
| 50. Stiffness in several joints | ❏ | ❏ | ❏ | ❏ |
| 51. General muscle aches or pains | ❏ | ❏ | ❏ | ❏ |
| 52. Loss of balance or coordination | ❏ | ❏ | ❏ | ❏ |
| 53. Difficulty speaking | ❏ | ❏ | ❏ | ❏ |
| 54. Low back pain | ❏ | ❏ | ❏ | ❏ |
| 55. Night sweats which soak the bed sheets | ❏ | ❏ | ❏ | ❏ |
| 56. Feeling feverish | ❏ | ❏ | ❏ | ❏ |
| 57. Tender or painful swelling of lymph glands in neck, armpit or groin | ❏ | ❏ | ❏ | ❏ |
| 58. Loss of, or decrease in, appetite | ❏ | ❏ | ❏ | ❏ |
| 59. Nausea | ❏ | ❏ | ❏ | ❏ |
| 60. Vomiting | ❏ | ❏ | ❏ | ❏ |
| 61. Distressing dreams | ❏ | ❏ | ❏ | ❏ |
| 62. Unintended weight gain greater than 4kg | ❏ | ❏ | ❏ | ❏ |
| 63. Unintended weight loss greater than 4kg | ❏ | ❏ | ❏ | ❏ |

*Please indicate whether or not you have experienced any of the following symptoms in the* ***PAST MONTH****.*

|  |  |  |
| --- | --- | --- |
| **In the past month have you experienced** | **NO** | **YES** |
| 64. Difficulty lifting objects above your head, or from a high shelf | ❏ | ❏ |
| 65. Difficulty undoing buttons | ❏ | ❏ |
| 66. Difficulty turning doorknobs or unscrewing jars | ❏ | ❏ |
| 67. Difficulty getting up from sitting in a chair or couch without the use of your arms | ❏ | ❏ |
| 68. Problems with tripping, or your feet slapping, while walking | ❏ | ❏ |
| 69. Difficulty recognising hot from cold water | ❏ | ❏ |
| 70. Difficulty feeling pain, cuts or injuries | ❏ | ❏ |
| 71. Feeling unsteady walking on uneven ground | ❏ | ❏ |
| 72. Feeling unsteady walking in the dark | ❏ | ❏ |
| 73. Feeling like you may fall over because of your unsteadiness | ❏ | ❏ |
| 74. Numbness, 'asleep feeling' or prickling sensation in your hands or arms | ❏ | ❏ |
| 75. Numbness, 'asleep feeling' or prickling sensation in your feet or legs | ❏ | ❏ |
| 76. Burning, deep aching pain or tenderness in your hands or arms | ❏ | ❏ |
| 77. Burning, deep aching pain or tenderness in your feet or legs | ❏ | ❏ |
| 78. Unusual sensitivity or tenderness of your skin when clothes or bedclothes rub against you | ❏ | ❏ |
| 79. Feeling like you will faint, or fainting, when you stand up from a lying or sitting position | ❏ | ❏ |
| 80. Difficulty swallowing food (more than occasionally) | ❏ | ❏ |

**G21. DIAGNOSED OR TREATED MEDICAL CONDITIONS**

We would like to know whether a medical doctor has ever diagnosed you with, or treated you for, any of the following medical problems or conditions.

*If YES, please indicate the year you were first diagnosed, and whether you have been treated by a medical doctor for this condition in the past year.*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Has a medical doctor ever diagnosed you with, or treated you for any of the following medical problems or conditions?** | **NO** | **YES** | **If YES** | | **Office only** | | |
| **Year first diagnosed** | **Treated by a doctor in the past year** |
| 1. High blood pressure | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 2. Heart disease or condition | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 3. Stroke | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 4. Epilepsy | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 5. Migraines | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 6. Motor neurone disease | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 7. Multiple sclerosis | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 8. Asthma | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 9. Bronchitis | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 10. Pneumonia | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 11. Tuberculosis (TB) | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 12. Other lung disease, e.g. emphysema | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 13. Stomach or duodenal ulcers | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 14. Colitis / Crohn's disease | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 15. Hepatitis or yellow jaundice | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 16. Cirrhosis of the liver | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 17. Bowel disorder e.g. diarrhoea, constipation, bleeding | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
|  | | |
| 18. Irritable bowel syndrome | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 19. Kidney disease e.g. stones, infection, bleeding | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
|  | | |
| 20. Bladder disease e.g. infection, bleeding | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 21. Incontinence or difficulty passing urine | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 22. Diabetes | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 23. A thyroid problem | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 24. Blood disorder; e.g. anaemia | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 25. Malaria | ❏ | ❏ |     | ❏NO ❏YES |  |  |  |
| 26. Any significant infections e.g. hepatitis, HIV, pneumonia, glandular fever, leishmaniasis | ❏ | ❏ |     | ❏NO ❏YES |  |  |  |
|  | | |
| 27. Arthritis or rheumatism | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 28. Fibrositis or fibromyalgia | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |
| 29. Back or neck problems | ❏ | ❏ |     | ❏ NO ❏ YES |  |  |  |

**Has a medical doctor ever diagnosed you**

**If YES Office**

**with, or treated you for any of the following**

**medical problems or conditions? NO YES**

**Year first diagnosed**

**Treated by a doctor in the past year**

**only**

30. Joint problems ❏ ❏     ❏ NO ❏ YES

31. Eye or vision problems e.g. glaucoma ❏ ❏     ❏ NO ❏ YES

32. Sinus problems ❏ ❏     ❏ NO ❏ YES

33. Ear infection ❏ ❏     ❏ NO ❏ YES

34. Hearing loss ❏ ❏     ❏ NO ❏ YES

35. Dermatitis ❏ ❏     ❏ NO ❏ YES

36. Eczema ❏ ❏     ❏ NO ❏ YES

37. Psoriasis ❏ ❏     ❏ NO ❏ YES

38. Malignant melanoma ❏ ❏     ❏ NO ❏ YES

39. Other skin cancer e.g. squamous cell or basal cell skin cancers

40. Any other kind of cancer, tumour or malignancy (please specify type)

❏ ❏     ❏ NO ❏ YES

❏ ❏     ❏ NO ❏ YES

41. Any other skin problem ❏ ❏     ❏ NO ❏ YES

42. Any disease of the hair or scalp, including hair loss

❏ ❏     ❏ NO ❏ YES

43. Chronic Fatigue Syndrome ❏ ❏     ❏ NO ❏ YES

44. Alcohol abuse or dependency ❏ ❏     ❏ NO ❏ YES

45. Drug abuse or dependency ❏ ❏     ❏ NO ❏ YES

46. Anxiety, stress or depression ❏ ❏     ❏ NO ❏ YES

47. Post Traumatic Stress Disorder ❏ ❏     ❏ NO ❏ YES

48. Other psychiatric or psychological

condition needing treatment or counseling (please specify type)

❏ ❏     ❏ NO ❏ YES

49. Sleep apnoea ❏ ❏     ❏ NO ❏ YES

50. Narcolepsy ❏ ❏     ❏ NO ❏ YES

51. Hayfever ❏ ❏     ❏ NO ❏ YES

52. Yeast disease or candidiasis ❏ ❏     ❏ NO ❏ YES

53. Multiple chemical sensitivity or environmental illness

❏ ❏     ❏ NO ❏ YES

54. Sick building syndrome ❏ ❏     ❏ NO ❏ YES

55. Food allergy ❏ ❏     ❏ NO ❏ YES

56. Any disease of the genital organs ❏ ❏     ❏ NO ❏ YES

57. Low fertility ❏ ❏     ❏ NO ❏ YES

58. Sexual problems ❏ ❏     ❏ NO ❏ YES

*WOMEN ONLY:*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Has a medical doctor ever diagnosed you with, or treated you for any of the following medical problems or conditions?** | **NO** | **YES** | **If YES** | | **Office only** | | |
| **Year first diagnosed** | **Treated by a doctor in the past year** |
| 59. Premenstrual tension | ❏ | ❏ |   | ❏ NO ❏ YES |  |  |  |
| 60. Period problems | ❏ | ❏ |   | ❏ NO ❏ YES |  |  |  |
| 61. Miscarriages | ❏ | ❏ |   | ❏ NO ❏ YES |  |  |  |

*EVERYONE COMPLETE THE NEXT QUESTIONS:*

**G22. Apart from those listed in the table at G21, are there any other medical problems or conditions which a medical doctor has diagnosed you with, or treated you for?**

❏ NO ❏ YES

If YES, please complete the following table indicating which condition/s, what year were you first diagnosed, and have you been treated for that condition by a medical doctor in the past year?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **G10a. Which condition** | **Year first diagnosed** | **Treated by a doctor in the past year** | **Office only** | | |
|  |   | ❏ NO ❏ YES |  |  |  |
|  |   | ❏ NO ❏ YES |  |  |  |
|  |   | ❏ NO ❏ YES |  |  |  |
|  |   | ❏ NO ❏ YES |  |  |  |

**G23. During the past twelve months have you been hospitalised overnight or longer because of illness or injury?**

❏ NO ❏ YES

If YES, please specify why and for how many days:

1st hospitalisation in past 12 months days Why?

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

2nd hospitalisation in past 12 months days Why?

3rd hospitalisation in past 12 months days Why?

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

4th hospitalisation in past 12 months days Why?

**G24. Thinking back over the past two weeks, did you stay in bed or at home all or part of any day because you did not feel well or as a result of illnesses or injury?**

❏ NO ❏ YES

**G25. Have you EVER had an allergic reaction to any medication?**

|  |  |  |  |
| --- | --- | --- | --- |
| ❏ NO | ❏ | YES |  |
|  | If YES, which medications: | |  |
|  | | | |
|  | | | |
|  | | | |

**G26. Are you CURRENTLY taking any medicines including tablets, creams, inhalers, or other drugs?**

❏ NO ❏ YES

If YES, what kind:

❏ tablets

❏ creams

❏ inhalers

❏ other drugs

please name them please name them please name them

please name them

**FAMILY HISTORY**

**G27. Has anyone in your immediate family** (that is your parents, brothers, sisters or

|  |  |  |
| --- | --- | --- |
| grandparents) **had a history of:** | | |
| a. Asthma? | ❏ NO | ❏ YES |
| b. A stroke when they were less than 65 years of age? | ❏ NO | ❏ YES |
| c. A heart attack when they were less than 65 years of age? | ❏ NO | ❏ YES |
| d. Diabetes? | ❏ NO | ❏ YES |
| e. Cancer? | ❏ NO | ❏ YES |

**If YES to cancer at G27e**, *please complete the following table, indicating the relationship of the family member to you, the type of cancer and the family member's age at diagnosis*. If NO, go to question G28.

|  |  |  |
| --- | --- | --- |
| **Relationship of family member to you** | **Type of cancer** | **Age at diagnosis** |
| Example: father | bowel | 55 yrs |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

G. HEALTH

**SMOKING & ALCOHOL**

**G28. Over your lifetime, would you have smoked as much as 100 cigarettes or a similar amount of tobacco?**

❏ **YES** ❏ **NO**

*If Yes go to Question G29 If NO go question G31 over the page*

**G29. Do you currently smoke as much as one cigarette per day (or 1 cigar per week or 1 ounce of tobacco per month)?**

|  |  |  |
| --- | --- | --- |
| ❏ **NO** | ❏ **YES** |  |
|  | **If YES** | **a. How old were you when you started smoking as much as one cigarette per day (or 1 cigar per week or 1 ounce of tobacco per month)?** |
| Age in years | | |
| **b. What is the average number of cigarettes per day, grams of tobacco per day and/or number of cigars per week that you currently smoke?** | | |
| cigarettes per day | | |
| grams of tobacco per day (donít include tobacco from cigarettes or cigars) | | |
| cigars per week | | |

*If NO to G29 answer G30. If YES to G29 go to question G31 next page*

**G30. Have you ever smoked as much as one cigarette per day (or 1 cigar per week or 1 ounce of tobacco per month)?**

|  |  |  |
| --- | --- | --- |
| ❏ **NO** | ❏ **YES** |  |
|  | **If YES:** | **a. How old were you when you started smoking as much as one cigarette** |
| **per day (or 1 cigar per week or 1 ounce of tobacco per month)?** | | |
|  | | |
| Age in years | | |
| **b. How old were you when you stopped smoking as much as one cigarette** | | |
| **per day (or 1 cigar per week or 1 ounce of tobacco per month)?** | | |
|  | | |
| Age in years | | |
| **c. What was the average number of cigarettes per day, grams of tobacco** | | |
| **per day and/or number of cigars per week that you smoked?** | | |

cigarettes per day

grams of tobacco per day (donít include tobacco from cigarettes or cigars)

cigars per week

*GO TO question G31.*

G. HEALTH

**G31. How often do you have a drink containing alcohol?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ❏ Never | ❏ Once a month | ❏ 2 to 4 times a | ❏ 2 to 3 times a | ❏ 4 or more times |
|  | or less | month | week | a week |
| *If* Never, *GO TO QUESTION G41.* | | | | |

*In answering the following questions, please remember that a standard drink contains*

*10g of pure alcohol*

**Each of these is**

|  |  |  |  |
| --- | --- | --- | --- |
| **1 Middy/Pot of**  **Standard Beer** | **1 Glass of Wine** | **1 Glass of**  **Sherry or Port** | **1 Nip of Spirits** |

**a standard drink:**

**G32. How many 'standard' drinks (see above) containing alcohol do you have on a typical day when you are drinking?**

❏ 1 or 2 ❏ 3 or 4 ❏ 5 or 6 ❏ 7 to 9 ❏ 10 or more

**G33. How often do you have six or more drinks on one occasion?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ❏ Never | ❏ Less than once | ❏ Monthly | ❏ Weekly | ❏ Daily or almost |
|  | a month |  |  | daily |

**G34. How often during the last 3 months have you found that you were not able to stop drinking once you had started?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ❏ Never | ❏ Less than once | ❏ Monthly | ❏ Weekly | ❏ Daily or almost |
|  | a month |  |  | daily |

**G35. How often during the last 3 months have you failed to do what was normally expected from you because of drinking?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ❏ Never | ❏ Less than once | ❏ Monthly | ❏ Weekly | ❏ Daily or almost |
|  | a month |  |  | daily |

**G36. How often during the last 3 months have you needed a drink in the morning to get yourself going after a heavy drinking session?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ❏ Never | ❏ Less than once | ❏ Monthly | ❏ Weekly | ❏ Daily or almost |
|  | a month |  |  | daily |

**G37. How often during the last 3 months have you had a feeling of guilt or remorse after drinking?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ❏ Never | ❏ Less than once | ❏ Monthly | ❏ Weekly | ❏ Daily or almost |
|  | a month |  |  | daily |

**G38. How often during the last 3 months have you been unable to remember what happened the night before because you had been drinking?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ❏ Never | ❏ Less than once | ❏ Monthly | ❏ Weekly | ❏ Daily or almost |
|  | a month |  |  | daily |

**G39. Have you or someone else been injured as a result of your drinking?**

❏ No ❏ Yes, but not in the last 3 months ❏ Yes, during the last 3 months

**G40. Has a relative, a friend, a doctor or other health professional been concerned about your drinking or suggested you cut down?**

❏ No ❏ Yes, but not in the last 3 months ❏ Yes, during the last 3 months

**LIFE EXPERIENCES**

G. HEALTH

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences.

*Please consider the event or group of events, military or non-military, in your life that you found most stressful or upsetting. Read the list of problems and complaints below and indicate how much you have been bothered by each problem or complaint* ***in the past month*** *in relation to that stressful experience.*

**G41a. The event, or group of events, you experienced was in**

Event/s year

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **G41b. As a result of that/those events have you had:** | **Not at all** | **A little bit** | **Moderately** | **Quite a bit** | **Extremely** |
| 1. Repeated, disturbing *memories, thoughts*  or *images* of the stressful experience? | ❏ | ❏ | ❏ | ❏ | ❏ |
| 2. Repeated, disturbing *dreams* of the stressful experience? | ❏ | ❏ | ❏ | ❏ | ❏ |
| 3. Suddenly *acting* or *feeling* as if the stressful experience *were happening again* (as if you were reliving it)? | ❏ | ❏ | ❏ | ❏ | ❏ |
| 4. Feeling *very upset* when *something reminded you* of the stressful experience? | ❏ | ❏ | ❏ | ❏ | ❏ |
| 5. Having *physical reactions* (eg heart pounding, trouble breathing, sweating) when *something reminded you* of the stressful experience? | ❏ | ❏ | ❏ | ❏ | ❏ |
| 6. Avoiding *thinking about or talking about* the stressful experience or avoiding *having feelings* related to it? | ❏ | ❏ | ❏ | ❏ | ❏ |
| 7. Avoiding *activities or situations* because *they reminded you* of the stressful experience? | ❏ | ❏ | ❏ | ❏ | ❏ |
| 8. Trouble *remembering important parts* of the stressful experience? | ❏ | ❏ | ❏ | ❏ | ❏ |
| 9. *Loss of interest* in activities that you used to enjoy? | ❏ | ❏ | ❏ | ❏ | ❏ |
| 10. Feeling *distant or cut off* from other people? | ❏ | ❏ | ❏ | ❏ | ❏ |
| 11. Feeling *emotionally numb* or being unable to have loving feelings for those close to you? | ❏ | ❏ | ❏ | ❏ | ❏ |
| 12. Feeling as if your *future* somehow will be  *cut short?* | ❏ | ❏ | ❏ | ❏ | ❏ |
| 13. Trouble *falling or staying asleep?* | ❏ | ❏ | ❏ | ❏ | ❏ |
| 14. Feeling *irritable* or having *angry outbursts?* | ❏ | ❏ | ❏ | ❏ | ❏ |
| 15. Having *difficulty concentrating?* | ❏ | ❏ | ❏ | ❏ | ❏ |
| 16. Being *"super alert"* or watchful or on guard? | ❏ | ❏ | ❏ | ❏ | ❏ |
| 17. Feeling *jumpy* or easily startled? | ❏ | ❏ | ❏ | ❏ | ❏ |

**YOUR CHILDREN'S HEALTH AND YOUR PREGNANCY HISTORY (including your partner's)**

We would now like to ask you some questions about your pregnancy history (if you are female) or that of your spouse/partner/s (if you are male). You may need to refer to your spouse/partner/s, or to your Child Health Record, to assist you in answering these questions. Your answers to these questions will help us compare your experience with information held in Australian National Registries, as well as the experiences of military personnel and their families as a whole.

**G42. How many times have you EVER been pregnant or fathered a pregnancy**?

times

please specify

*If your answer to G42 is zero (0) please GO TO G47. If one or more, proceed with*

*G43.*

**G43. Have any of these pregnancies resulted in:**

|  |  |  |
| --- | --- | --- |
| a miscarriage | ❏ NO | ❏ YES |
| a still birth | ❏ NO | ❏ YES |
| a termination of pregnancy | ❏ NO | ❏ YES |

**G44. If you answered YES in question G43, please provide additional information, if known, about those particular pregnancies in the following table.**

*If you answered NO, please GO TO G45.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PREGNANCY EVENT** | 1st pregnancy | 2nd pregnancy | 3rdpregnancy | 4th pregnancy | 5th pregnancy |
| **Miscarriage Still birth Termination** | ❏  ❏  ❏ | ❏  ❏  ❏ | ❏  ❏  ❏ | ❏  ❏  ❏ | ❏  ❏  ❏ |
| **Date of the event** | \_ \_ / \_ \_/ \_ \_ \_ \_ | \_ \_ / \_ \_/ \_ \_ \_ \_ | \_ \_ / \_ \_/ \_ \_ \_ \_ | \_ \_ / \_ \_/ \_ \_ \_ \_ | \_ \_ / \_ \_/ \_ \_ \_ \_ |
| **Hospital name** |  |  |  |  |  |
| **Hospital State** |  |  |  |  |  |
| **Known cause of the event or physical problem, if any** |  |  |  |  |  |
| **Baby's sex**  if known | ❏ Male  ❏ Female  ❏ Not known | ❏ Male  ❏ Female  ❏ Not known | ❏ Male  ❏ Female  ❏ Not known | ❏ Male  ❏ Female  ❏ Not known | ❏ Male  ❏ Female  ❏ Not known |
| **Mother's full name** at the time |  |  |  |  |  |
| **Mother's postcode**  at the time | ❏ Not known | ❏ Not known | ❏ Not known | ❏ Not known | ❏ Not known |
| **Mother's date of birth** | \_ \_ / \_ \_/ \_ \_ \_ \_  ❏ Not known | \_ \_ / \_ \_/ \_ \_ \_ \_  ❏ Not known | \_ \_ / \_ \_/ \_ \_ \_ \_  ❏ Not known | \_ \_ / \_ \_/ \_ \_ \_ \_  ❏ Not known | \_ \_ / \_ \_/ \_ \_ \_ \_  ❏ Not known |

**G45a. For all of your live born children, please list their name, date of birth, sex, and birth weight (if known) and number of weeks the baby was when it was born.**

**(Nb. Full term is 40 weeks).**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **1st child** | **2nd child** | **3rd child** | **4th child** | **5th child** |
| **Child's full name** |  |  |  |  |  |
| **Date of birth** | \_ \_ / \_ \_/ \_ \_ \_ \_ | \_ \_ / \_ \_/ \_ \_ \_ \_ | \_ \_ / \_ \_/ \_ \_ \_ \_ | \_ \_ / \_ \_/ \_ \_ \_ \_ | \_ \_ / \_ \_/ \_ \_ \_ \_ |
| **Sex** | ❏ Male  ❏ Female | ❏ Male  ❏ Female | ❏ Male  ❏ Female | ❏ Male  ❏ Female | ❏ Male  ❏ Female |
| **Birth weight**  If known | grams or  lbs oz  ❏ Not known | grams or  lbs oz  ❏ Not known | grams or  lbs oz  ❏ Not known | grams or  lbs oz  ❏ Not known | grams or  lbs oz  ❏ Not known |
| **Number of weeks pregnant when baby was born** (if known) | weeks  ❏ Not known | weeks  ❏ Not known | weeks  ❏ Not known | weeks  ❏ Not known | weeks  ❏ Not known |

**G45b. Have any of these**

**children died, had a cancer,** ❏ **NO** *Go to question G46*

**birth defect, or other serious** ❏ **YES** *Please complete the rest of the table below, keeping the*

**health problem?** *information in the corresponding column for the child or children above*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Cancers?** | ❏ NO ❏ YES  specify type | ❏ NO ❏ YES  specify type | ❏ NO ❏ YES  specify type | ❏ NO ❏ YES  specify type | ❏ NO ❏ YES  specify type |
| **Birth defects or chromosomal abnormalities?** | ❏ NO ❏ YES  specify type | ❏ NO ❏ YES  specify type | ❏ NO ❏ YES  specify type | ❏ NO ❏ YES  specify type | ❏ NO ❏ YES  specify type |
| **Other serious health problems?** | ❏ NO ❏ YES  specify type | ❏ NO ❏ YES  specify type | ❏ NO ❏ YES  specify type | ❏ NO ❏ YES  specify type | ❏ NO ❏ YES  specify type |
| **Has any child died?** | ❏ NO ❏ YES  \_ \_ / \_ \_ / \_ \_ \_ \_  specify date  specify cause of death | ❏ NO ❏ YES  \_ \_ / \_ \_ / \_ \_ \_ \_  specify date  specify cause of death | ❏ NO ❏ YES  \_ \_ / \_ \_ / \_ \_ \_ \_  specify date  specify cause of death | ❏ NO ❏ YES  \_ \_ / \_ \_ / \_ \_ \_ \_  specify date  specify cause of death | ❏ NO ❏ YES  \_ \_ / \_ \_ / \_ \_ \_ \_  specify date  specify cause of death |
| **Name of Hospital of birth** |  |  |  |  |  |
| **Hospital State** |  |  |  |  |  |
| **Mother's full name**  at the time of birth |  |  |  |  |  |
| **Mother's postcode**  at the time of birth | ❏ Not known | ❏ Not known | ❏ Not known | ❏ Not known | ❏ Not known |
| **Mother's date of birth** | \_ \_ / \_ \_/ \_ \_ \_ \_  ❏ Not known | \_ \_ / \_ \_/ \_ \_ \_ \_  ❏ Not known | \_ \_ / \_ \_/ \_ \_ \_ \_  ❏ Not known | \_ \_ / \_ \_/ \_ \_ \_ \_  ❏ Not known | \_ \_ / \_ \_/ \_ \_ \_ \_  ❏ Not known |

**G46. Have any of your pregnancies or births involved twins or multiple births?**

❏ NO ❏ YES

**If YES describe which ones from the tables at G44 and G45.**

example: Table G45, 2nd child and 3rd child are twins.

**G47. Have you and your partner ever experienced difficulties getting pregnant despite trying for at least 12 months?**

❏ NO ❏ YES

**If YES:**

**a. What year did those difficulties getting pregnant begin?**

year

**b. Have you sought or undertaken infertility treatment?**

❏ NO ❏ YES

**c. If YES, was there any cause for your infertility found?**

❏ NO ❏ YES

please specify

**d. Have you managed to get pregnant or father a pregnancy since then?**

❏ NO ❏ YES **Which year?**

year

*GO TO SECTION H.*

H. FINAL QUESTIONS

**Section H. FINAL QUESTIONS**

*As a check of our coverage in this questionnaire, please answer these final questions.*

**H1. Are there other important military experiences or exposures we have not asked you about?**

❏ NO ❏ YES

If YES, please give details in the space provided here.

**H2. Are there other important health concerns we have not asked you about?**

❏ NO ❏ YES

If YES, please give details in the space provided here.

**H3. Do you have any additional comments you would like to add?**

❏ NO ❏ YES

If YES, please give details in the space provided here or on additional pages.

**SECTION I: CONTACT DETAILS**

***Note: to ensure confidentiality of your information, this page will be removed by the Study team and stored separately from the rest of the questionnaire.***

**Please fill in details of your current name**

Surname

All given names

Your preferred given name

**If you have ever changed your name please provide details here.**

Previous surname

Given names if different

Years used (start/end) to

Other previous surname

Other given names

Years used (start/end) to

**Please give your current address, telephone contact numbers and email address**

**(if applicable)**

Street number or PO Box

Street

Suburb/Town

State Postcode

Phone numbers Email address/es

Home Home

Work Work

Mobile

**ALTERNATIVE CONTACT DETAILS**

**INSTRUCTIONS**: *In case you move and we lose contact with you, please give us the names of up to two relatives or friends who may be able to tell us where you are. These should be people who are at long-term addresses but who are not living with you. We would only use these alternative contacts in the event that we could not contact you at the address you have provided on the previous page.*

**FIRST ALTERNATIVE CONTACT**

Surname

Given names

Street number Street Suburb/Town

State Postcode

Phone no/s

**SECOND ALTERNATIVE CONTACT**

Surname

Given names

Street number Street Suburb/Town

State Postcode

Phone no/s

J. NOMINATED MEDICAL PRACTITIONER

**SECTION J: NOMINATED MEDICAL PRACTITIONER**

*Upon completion of your medical assessments, at Health Services Australia, a summary of your results will be sent to you. This will include results of the blood tests and results of various tests of physical and mental functioning.*

*If Health Services Australia find a condition that requires further medical follow up or investigation, it is very important that they forward that information to an appropriate medical practitioner.*

*The Study team invites you to nominate a personal medical practitioner or general practitioner to whom we can send a second copy of your results.*

*If you do not have a personal medical practitioner or some other local practitioner who you care to nominate, OR if you only have an Australian Defence Force medical practitioner to whom you do not wish results to go, Health Services Australia will send you a copy of your results as usual.*

**If you would like to nominate a medical practitioner, to receive a copy of your medical assessment results, please write their contact details here and sign the consent box below; providing Health Services Australia with your permission that they forward a second copy of your results to the nominated person.**

I wish to nominate a medical practitioner . ❑ YES ❑ NO Medical practitioner's name

Name of the medical practice

(business name)

Street number Street Suburb/Town

State Postcode

Phone no/s

I give my consent for Health Services Australia to send a copy of my medical examination results, collected for the purpose of the Gulf War Veterans Health Study, to the practitioner whom I have nominated above.

/ /

Name Signature Date

5. Medical Examination Data Collection Booklet

v

**STUDY NUMBER**



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**PARTICIPANT QUESTIONNAIRE**

OFFICE USE ONLY

PRE EXAM.

POST EXAM

INFORMED CONSENT STATEMENT

**Gulf War Veterans Health Study**

I agree to take part in the Gulf War Veterans Health Study. I have had the aims of the project, and the procedures therein, satisfactorily explained to me and I have had the opportunity to read and ask questions arising from the Explanatory Statement. In signing this consent form I am declaring the following:

I have read and understand the information about the Study and have had explained to me the

**1** aims of this research project, and the procedures in which I will be involved.

I understand that I will need to devote time to completing the various parts of the study including a self-administered questionnaire and a medical examination.

I understand that I will have blood taken for testing.

I understand that there are some inconveniences and risks involved in participation including potential emotional distress, associated with answering questions about my Service or life experiences, and mild discomfort associated with procedures such as skin testing, fitness testing, breathing tests and blood sampling.

I understand that I am participating in this project in a voluntary capacity and that I can withdraw at any time. This withdrawal will be without penalty or detriment to career or hindrance to future medical care.

I understand that if any medical condition, requiring further investigation or treatment, is found as a result of the medical examination, the appropriate feedback will be provided to me or to my nominated medical practitioner.

I am co-operating in this project on condition that:

• the information I provide and results of my assessments will be kept confidential and only used for this project.

• the research reports will be made available to me at my request and

• any published reports of this study will preserve my anonymity

I agree that a sample of my blood serum may be stored indefinitely for potential and further

**2** medical research. This serum can not be used for any such purpose without my further specific written consent.



I agree that the researchers may check the records of the National Cancer Registry and National

**3** Childhood Malformations Registry against information I provide about my childrens’ health.

**4** I agree that the researchers may check my name against the records of the National Cancer

Registry and National Deaths Registry.

**5** I also agree that the researchers may obtain my Australian Defence Force medical record.

**I consent to all of the above points 1 to 5.**

Name.............................................................. HSA Witness ...................................................

Signed...................................................... / /\_ Signed................................................... / /

**OR**

**I consent to all of the above points except number/s (please specify).**

Name.............................................................. HSA Witness ...................................................

Signed....................................................

/ /

Signed................................................... / /

**EMERGENCY CONTACT PERSON**

FIRST NAME: ………………………………………. SURNAME: ……………………………………….

PHONE: ……………………………………….(Home)

……………………………………….(Work)

……………………………………….(Mobile) Relationship ……………………………………….

(eg. spouse/parent/friend)

**NURSE ADMINISTERED DATA COLLECTION**

**INTERVIEWER CODE**

**DATE / /**

Day Month Year

**HEIGHT .** cm

|  |  |  |
| --- | --- | --- |
| *Does this person have a pacemaker?* | ❏ | *YES* |
|  | ❏ | *NO* |

*If yes, please do not use Tanita scales; specify other type*

**WEIGHT .** kilograms

**HIP .** cm

**WAIST .** cm

**BLOOD PRESSURE (Right arm)** ❏ left arm needed to be used

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Smoked in the previous hour? |  | ❏ | YES | ❏ | NO |
| Caffeine in the previous hour? |  | ❏ | YES | ❏ | NO |

Systolic 1 2

Diastolic

**VISUAL ACUITY** (corrected) **R** / **L** /

**SYMPTOMS OF TIREDNESS OR FATIGUE (T cell subset test selection)**

**1. In the past 12 months, have you experienced extreme tiredness or fatigue**

|  |  |  |
| --- | --- | --- |
| **following your normal activities?** | ❏  NO | ❏  YES |
| If YES, go to Question 2 |  |  |
| If NO, go to Question 3 |  |  |
| **In the past 12 months, have you felt extremely tired or fatigued following your normal activities every day, or almost every day, for one month or longer?** | ❏  NO | ❏  YES |
| If YES, go to instructions below |  |  |
| If NO, proceed to take blood and order routine blood tests only (not T cell subsets) |  |  |
| **Has a medical doctor ever diagnosed you with, or treated you for, Chronic**  **Fatigue Syndrome?** | ❏  NO | ❏  YES |
| If YES, proceed to take blood and order routine blood tests only (not T cell subsets) |  |  |
| If NO, see instructions below |  |  |

**2.**

**3.**

INSTRUCTIONS:

**If YES to Questions 1 and 2**

1. Record this person as a “CASE” in the “Log Sheet for Symptoms of Tiredness or Fatigue”

2. Take blood for, and order, T cell subsets in addition to routine blood tests

3. Look out for the next person who answers “NO” to both Questions 1 and 3 (see below)

**If NO to Questions 1 and 3**

1. Check the “Log Sheet for Symptoms of Tiredness or Fatigue”

2. If there is a “CASE” recorded that does not have a corresponding “CONTROL”, record this person as a “CONTROL” and take blood for, and order, T cell subsets in addition to routine blood tests

3. If all “CASES” recorded in the “Log Sheet” already have a corresponding “CONTROL”, proceed to take the blood and order routine blood tests only

**BLOOD SAMPLING.**

**Collect blood samples and complete data collection boxes below.**

**Have all routine blood samples been taken?**

❏ YES Time eg. 0800

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ❏  form) | NO | Refused to give sample for indefinite storage (as per section 2 on consent | | |
| ❏ | NO | Refused all blood sampling | | |
| ❏ | NO | Another reason | | |
|  |  | specify why | | |
| **Have T cell subsets been ordered?** | | | ❏ | YES, as a case |
|  | | | ❏  ❏ | YES, as a control  NO, not a case or control |

**INSTRUCTIONS: Administer skin test now, and proceed with asking respiratory questions**

**RESPIRATORY QUESTIONS**

**Wheeze and tightness in the chest**

1. Have you had wheezing or whistling in your chest at any time in the last 12 months?

Yes No

❏ ❏

If NO to this question If YES to this question

|  |  |  |
| --- | --- | --- |
| 1.1 Have you been at all breathless when the wheezing noise was present? | Yes  ❏ | No  ❏ |
| 1.2 Have you had this wheezing or whistling when you did not have a cold? | Yes  ❏ | No  ❏ |

|  |  |  |
| --- | --- | --- |
| 2. Have you woken up with a feeling of tightness in | Yes | No |
| your chest at any time in the last 12 months? | ❏ | ❏ |

**Shortness of breath**

3. Have you had an attack of shortness of breath that

|  |  |  |
| --- | --- | --- |
| came on during the day when you were AT REST at any | Yes | No |
| time in the last 12 months? | ❏ | ❏ |

4. Have you had an attack of shortness of breath that

|  |  |  |
| --- | --- | --- |
| came on FOLLOWING strenuous activity at any time | Yes | No |
| in the last 12 months? | ❏ | ❏ |

5. Have you been woken by an attack of shortness of Yes No breath at any time in the last 12 months? ❏ ❏

If NO to this question If YES to this question

5.1 Have you been woken by an attack of shortness Yes No

of breath in the past 3 months? ❏ ❏

|  |  |  |
| --- | --- | --- |
| 5.1.1 If YES, have you been woken by an attack of | Yes | No |
| shortness of breath at least once a week? | ❏ | ❏ |
| 5.1.2 If YES, how many times a week are you, on average, |  |  |

woken by an attack of shortness of breath? Times per week

**Cough and phlegm from the chest**

|  |  |  |  |
| --- | --- | --- | --- |
| 6. | Have you been woken by an attack of coughing at any time in the last 12 months? | Yes  ❏ | No  ❏ |
| 7. | Do you  **usually** cough first thing in the morning (or | Yes | No |
|  | getting up if on night shift)? | ❏ | ❏ |
|  | 7.1 Do you  **usually** cough first thing in the morning | Yes | No |
|  | in the winter? | ❏ | ❏ |
| 8. | Do you  **usually** cough during the day or at night? | Yes  ❏ | No  ❏ |
|  | 8.1 Do you  **usually** cough during the day, | Yes | No |
|  | or at night in the winter? | ❏ | ❏ |

If NO to all of these questions If YES to any of these questions

9. Would you have coughed like this for as much as Yes No

3 months in each of the past 2 years? ❏ ❏

10. Do you  **usually** bring up any phlegm from your Yes No chest first thing in the morning in winter? ❏ ❏

If NO to this question If YES to this question

|  |  |  |  |
| --- | --- | --- | --- |
| 10.1 Do you  **usually** bring up phlegm from your | | | |
| chest first thing in the morning in summer, spring | | Yes | No |
| and/or autumn? |  | ❏ | ❏ |
| 10.2 If YES, which seasons? | | ❏ Summer | |
|  | Choose all that apply | ❏ Spring | |
| ❏ Autumn | | | |

11. Do you  **usually** bring up any phlegm from your Yes No chest during the day, or at night in the winter? ❏ ❏

If NO to this question If YES to this question

|  |  |  |
| --- | --- | --- |
| 11.1 If YES, have you bought up phlegm like this on | | |
| most days for as much as 3 months of a year | Yes | No |
| for at least 2 successive years? | ❏ | ❏ |

**Breathing**

12. Do you ever have trouble with your breathing? Yes No

❏ ❏

If NO to this question If YES to this question

12.1 Do you have this trouble (choose one)

❏ continuously so that your breathing is never quite right?

❏ repeatedly, but it always gets completely better?

❏ only rarely?

13. Are you disabled from walking by a condition Yes No other than heart or lung disease? ❏ ❏

If YES, what condition?

14. Are you troubled by shortness of breath when Yes No hurrying on level ground or walking up a slight hill? ❏ ❏

If NO to this question If YES to this question

|  |  |  |
| --- | --- | --- |
| 14.1 Do you get short of breath walking with other people of your own age on level ground? | Yes  ❏ | No  ❏ |
| 14.2 If YES, do you have to stop for breath when walking at your own pace on level ground? | Yes  ❏ | No  ❏ |

go to next page

**Asthma**

15. Have you ever had asthma? Yes No

❏ ❏

If NO, **GO TO QUESTION 21** (Chronic Bronchitis)

16. Was this confirmed by a doctor?

17. How old were you when you had your first attack (or symptoms) of asthma?

Yes

❏

No

❏

years

18. How old were you when you had your most recent attack (or symptoms) of asthma?

years

19. Which months of the year do you usually have attacks of asthma?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ❏ | January | ❏ | May | ❏ | September |
| ❏ | February | ❏ | June | ❏ | October |
| ❏ | March | ❏ | July | ❏ | November |
| ❏ | April | ❏ | August | ❏ | December |

20. Have you had an attack of asthma in the last **12 months**? Yes No

❏ ❏

If NO to question 20 If YES to question 20

20.1 How many attacks of asthma have you had in the last **12 months**?

20.2 How many attacks of asthma have you had in the last **3 months**?

20.3. How often have you woken up because of your asthma in the last **3 months**? Choose one.

❏ Almost every night

❏ More that once a week

❏ More than twice a month

❏ Equal or less than once a month

❏ Not at all

20.4. How often have you had trouble with your breathing because of your asthma in the last **3 months**?

❏ Continuously

❏ Once a day

❏ More than twice a week

❏ Equal or less than twice a week

❏ Once a week

❏ Less than once a week

**Chronic Bronchitis**

21. Have you ever had chronic bronchitis? Yes No

❏ ❏

If NO to this question If YES to this question

|  |  |  |
| --- | --- | --- |
| 21.1 Was this confirmed by a doctor? | Yes | No |
|  | ❏ | ❏ |
| 21.2 At what age did it start? |  | years |

**Emphysema**

22. Have you ever had emphysema? Yes No

❏ ❏

If NO to this question If YES to this question

|  |  |  |
| --- | --- | --- |
| 22.1 Was this confirmed by a doctor? | Yes | No |
|  | ❏ | ❏ |
| 22.2 At what age did it start? |  | years |

Go to next page

|  |  |  |  |
| --- | --- | --- | --- |
| **SKIN TEST RESULTS** |  | | |
| Antihistamines in previous 4 days? |  | ❏  ❏ | YES NO |
| Maximum |  | Perpendicular |  |
| diameter |  | diameter |  |

Positive control Mould mix House dust mite Grass mix

Cat dander

Negative control

**LUNG FUNCTION TEST**

Contraindicated asthma medications within prescribed period?

❏ YES

❏ NO

|  |  |  |
| --- | --- | --- |
| Productive cough or cold in previous three weeks? | ❏ | YES |
|  | ❏ | NO |

*INSTRUCTIONS: Proceed with lung function test and attach results to page 10.*

**URINE SAMPLING**

PROTEIN at 60 seconds BLOOD at 60 seconds GLUCOSE at 30 seconds

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ❏ | neg | ❏ | neg | ❏ | neg |
| ❏ | trace | ❏ | trace | ❏ | trace |
| ❏ | 1+ | ❏ | small | ❏ | 1+ |
| ❏ | 2+ | ❏ | moderate | ❏ | 2+ |
| ❏ | 3+ | ❏ | large | ❏ | 3+ |
| ❏ | 4+ |  |  | ❏ | 4+ |

NITRITES

❏ Negative

❏ Positive

**Interviewer remained blinded to Gulf War status**

❏ **NO** ❏ **YES**

❏ **Postal questionnaire has been checked and stapled up to the start of Section G: Health.**

**Gulf War Vets only**

❏ **W.H.O. yellow vaccination booklet has been provided and photocopied**

❏ **W.H.O. yellow vaccination booklet NOT provided.**

**ADDITIONAL COMMENTS**

Attach lung function print out here

Attach the blood test results and carbon copy of pathology request form(s) here

Attach photocopy of W.H.O. yellow vaccination booklet here

Attach CIDI output to this page

**PTSD MODULE 2**

❑Not administered

This module should only be administered to participants who identify more than one stressful or upsetting event from the list on the card K1.

The CIDI-based PTSD module should already have been run for the event which the participant identified as the MOST stressful or upsetting.

**Question 1. You listed more than one stressful or upsetting event on Card K1, and we have already talked about the one which you identified as the most stressful or upsetting. Now I would like you to identify the next most stressful or upsetting event from the list.**

*Psychologist to tick the number, corresponding to the chosen event on K1, and give brief description for use during later questions.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ❑ | **1** |  | ❑ | **7** |
| ❑ | **2** |  | ❑ | **8** |
| ❑ | **3** |  | ❑ | **9** |
| ❑ | **4** |  | ❑ | **10** |
| ❑ | **5** |  | ❑ | **11** |
| ❑ | **6** |  |  |  |

K22B How old were you when (EVENT) happened? AGE:

Years

K22C When it happened, did you feel terrified? NO ................................ ❑

YES............................... ❑

K22D When it happened, did you feel helpless? NO ................................ ❑

YES............................... ❑

Now I would like to ask you about the time after the (EVENT)

happened to you.

K23 Did you keep remembering (EVENT) even when you didn't want to?

NO................................. ❑

YES ............................... ❑

K24 After it, did you keep having bad dreams or nightmares about it? NO................................. ❑

YES ............................... ❑

K25 Did you suddenly act or feel as though (EVENT) was happening again even though it wasn't?

NO................................. ❑

YES ............................... ❑

|  |  |  |
| --- | --- | --- |
| K26 | Did you get very upset when you were reminded of it? | NO................................. ❑  YES ............................... ❑ |
| K27 | Did you sweat or did your heart beat fast or did you tremble when | NO................................. ❑ |
|  | you were reminded of (EVENT)? | YES ............................... ❑ |

IF K23 TO K27 ALL CODED NO, SKIP TO PTSD Module 3 on

Page 17.

|  |  |  |
| --- | --- | --- |
| K28 | After (EVENT) did you have trouble sleeping? | NO................................. ❑  YES ............................... ❑ |
| K29 | After it, did you feel unusually irritable or lose your temper a lot more than is usual for you? | NO................................. ❑  YES ............................... ❑ |
| K30 | After it, did you have difficulty concentrating? | NO................................. ❑  YES ............................... ❑ |
| K31 | After (EVENT) did you become very much more concerned about danger or very much more careful? | NO................................. ❑  YES ............................... ❑ |
| K32 | After (EVENT) did you become jumpy or easily startled by ordinary noises or movements? | NO................................. ❑  YES ............................... ❑ |

IF K28 TO K32 ALL CODED NO, SKIP TO PTSD Module 3 on

Page 17

|  |  |  |
| --- | --- | --- |
| K33 | Did you deliberately try not to think or talk about (EVENT)? | NO................................. ❑  YES ............................... ❑ |
| K34 | Did you avoid places or people or activities that might have reminded you of it? | NO................................. ❑  YES ............................... ❑ |
| K35 | After (EVENT) was your memory blank for all or part of (EVENT)?  IF EVENT IDENTIFIED AT QUESTION ONE IS WITNESS OF AN ACCIDENT (CARD K1 ITEM 4) OR EVENT HAPPENED TO RELATIVES OR FRIENDS (CARD K1 ITEM 11), SKIP TO K36. OTHERS ASK: | NO......(SKIP TO K36) .. ❑  YES ............................... ❑ |
|  | A. Did you suffer a head injury as a result of (EVENT)? | NO................................. ❑  YES ............................... ❑ |
|  | B. Were you unconscious for more than ten minutes? | NO................................. ❑  YES ............................... ❑ |
| K36 | After (EVENT) did you lose interest in doing things that were once important or enjoyable for you? | NO................................. ❑  YES ............................... ❑ |

K37 After (EVENT) did you feel more isolated or distant from other people?

K38 After (EVENT) did you find you had more difficulty experiencing normal feelings such as love or affection towards other people?

K39 After (EVENT) did you begin to feel that there was no point in thinking about the future anymore?

IF K33 TO K39 ALL CODED NO, SKIP TO PTSD Module 3 on

Page 17

NO................................. ❑

YES ............................... ❑

NO................................. ❑

YES ............................... ❑

NO................................. ❑

YES ............................... ❑

K40 You said that you had problems after (EVENT) like (review items coded YES in K23 to K39).

How soon after (EVENT) did you start to have any of these problems? CODE SHORTEST NUMBER.

IF MORE THAN 1 YEAR, ASK: How old were you?

K41 How long did you continue to have any of these problems because of (EVENT)? CODE SHORTEST TIME.

K42 When was the last time you had any of these problems as a result of (EVENT)?

IF MORE THAN ONE YEAR, ASK: How old were you?

SAME DAY……………………❑ THAT WEEK………………….❑ THAT MONTH………………...❑ WITHIN 6 MONTHS………….❑ WITHIN 1 YEAR………………❑ MORE THAN 1 YEAR….…....❑

AGE (years)

LESS THAN 1 WEEK………..❑ LESS THAN 1 MONTH......... ❑ LESS THAN 6 MONTHS…....❑ LESS THAN 1 YEAR………...❑ MORE THAN 1 YEAR……….❑

LESS THAN 1 WEEK………..❑ LESS THAN 1 MONTH......... ❑ LESS THAN 6 MONTHS…....❑ LESS THAN 1 YEAR………...❑ MORE THAN 1 YEAR……….❑

AGE (years):

**PTSD Module 2** continued

K43 Did you tell a doctor about the problems that occurred as a result of (EVENT)?

1. Did you tell any other professional?

2. Did you take medication, or use drugs or alcohol more than once for the problems which occurred as a result of it?

3. Did the problems which occurred as a result of it interfere with your life or activities a lot?

K44 Have you ever been very upset with yourself for having the problems which occurred as a result of (EVENT)?

K45 Have the problems which occurred as a result of (EVENT)

ever kept you from going to a party, social event or meeting?

NO ......... ......................... ❑

YES........ (SKIP TO 2) ..... ❑

NO .................................❑

YES ...............................❑

NO .................................❑

YES ...............................❑

NO .................................❑

YES ...............................❑

NO .................................❑

YES ...............................❑

NO .................................❑

YES ...............................❑

❑Not Administered

**PTSD MODULE 3**

This module should only be administered to participants who identify more than TWO stressful or upsetting events from the list on the card K1.

The CIDI-based PTSD module should already have been run for the event which the participant identified as the MOST stressful or upsetting. PTSD Module 2 should have been administered for the next most stressful or upsetting event.

**Question 1. You listed more than two stressful or upsetting events on Card K1, and we have already talked about the two which you identified as the most stressful or upsetting. Now I would like you to identify the next most stressful or upsetting event from the list.**

*Psychologist to tick the number, corresponding to the chosen event on K1, and give brief description for use during later questions.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ❑ | **1** |  | ❑ | **7** |  |
| ❑ | **2** |  | ❑ | **8** |  |
| ❑ | **3** |  | ❑ | **9** |  |
| ❑ | **4** |  | ❑ | **10** |  |
| ❑ | **5** |  | ❑ | **11** |  |
| ❑ | **6** |  |  |  |  |

K22B How old were you when (EVENT) happened? AGE:

Years

K22C When it happened, did you feel terrified? NO ................................ ❑

YES............................... ❑

K22D When it happened, did you feel helpless? NO ................................ ❑

YES............................... ❑

Now I would like to ask you about the time after the (EVENT)

happened to you.

K23 Did you keep remembering(EVENT) even when you didn't want to?

K24 After it, did you keep having bad dreams or nightmares about it?

K25 Did you suddenly act or feel as though (EVENT) was happening again even though it wasn't?

NO................................. ❑

YES ............................... ❑

NO................................. ❑

YES ............................... ❑

NO................................. ❑

YES ............................... ❑

|  |  |  |
| --- | --- | --- |
| K26 | Did you get very upset when you were reminded of it? | NO................................. ❑  YES ............................... ❑ |
| K27 | Did you sweat or did your heart beat fast or did you tremble when | NO................................. ❑ |
|  | you were reminded of (EVENT)? | YES ............................... ❑ |

IF K23 TO K27 ALL CODED NO, THIS MODULE IS COMPLETE, RETURN TO THE CIDI INTERVIEW

|  |  |  |
| --- | --- | --- |
| K28 | After (EVENT) did you have trouble sleeping? | NO................................. ❑  YES ............................... ❑ |
| K29 | After it, did you feel unusually irritable or lose your temper a lot more than is usual for you? | NO................................. ❑  YES ............................... ❑ |
| K30 | After it, did you have difficulty concentrating? | NO................................. ❑  YES ............................... ❑ |
| K31 | After (EVENT) did you become very much more concerned about danger or very much more careful? | NO................................. ❑  YES ............................... ❑ |
| K32 | After (EVENT) did you become jumpy or easily startled by ordinary noises or movements? | NO................................. ❑  YES ............................... ❑ |

IF K28 TO K32 ALL CODED NO, THIS MODULE IS COMPLETE, RETURN TO THE CIDI INTERVIEW

|  |  |  |
| --- | --- | --- |
| K33 | Did you deliberately try not to think or talk about (EVENT)? | NO................................. ❑  YES ............................... ❑ |
| K34 | Did you avoid places or people or activities that might have reminded you of it? | NO................................. ❑  YES ............................... ❑ |
| K35 | After (EVENT) was your memory blank for all or part of (EVENT)?  IF EVENT IDENTIFIED AT QUESTION ONE IS WITNESS OF AN ACCIDENT (CARD K1 ITEM 4) OR EVENT HAPPENED TO RELATIVES OR FRIENDS (CARD K1 ITEM 11), SKIP TO K36. OTHERS ASK: | NO......(SKIP TO K36) .. ❑  YES ............................... ❑ |
|  | A. Did you suffer a head injury as a result of (EVENT)? | NO................................. ❑  YES ............................... ❑ |
|  | B. Were you unconscious for more than ten minutes? | NO................................. ❑  YES ............................... ❑ |
| K36 | After (EVENT) did you lose interest in doing things that were once important or enjoyable for you? | NO................................. ❑  YES ............................... ❑ |

|  |  |  |
| --- | --- | --- |
| K37 | After (EVENT) did you feel more isolated or distant from other people? | NO................................. ❑  YES ............................... ❑ |
| K38 | After (EVENT) did you find you had more difficulty experiencing | NO................................. ❑ |
|  | normal feelings such as love or affection towards other people? | YES ............................... ❑ |
| K39 | After (EVENT) did you begin to feel that there was no point in | NO................................. ❑ |
|  | thinking about the future anymore? | YES ............................... ❑ |

IF K33 TO K39 ALL CODED NO, THIS MODULE IS COMPLETE, RETURN TO THE CIDI INTERVIEW

K40 You said that you had problems after (EVENT) like (review items coded YES in K23 to K39).

How soon after (EVENT) did you start to have any of these problems? CODE SHORTEST NUMBER.

IF MORE THAN 1 YEAR, ASK: How old were you?

K41 How long did you continue to have any of these problems because of (EVENT)? CODE SHORTEST TIME.

K42 When was the last time you had any of these problems as a result of (EVENT)?

IF FOR MORE THAN ONE YEAR, ASK: How old were you?

SAME DAY……………………❑ THAT WEEK………………….❑ THAT MONTH………………...❑ WITHIN 6 MONTHS………….❑ WITHIN 1 YEAR………………❑ MORE THAN 1 YEAR….…....❑

AGE (years)

LESS THAN 1 WEEK………..❑ LESS THAN 1 MONTH..........❑ LESS THAN 6 MONTHS…....❑ LESS THAN 1 YEAR………...❑ MORE THAN 1 YEAR……….❑

LESS THAN 1 WEEK………..❑ LESS THAN 1 MONTH..........❑ LESS THAN 6 MONTHS…....❑ LESS THAN 1 YEAR………...❑ MORE THAN 1 YEAR……….❑

AGE (years):

**PTSD Module 3** continued

K43 Did you tell a doctor about the problems that occurred as a result of (EVENT)?

1. Did you tell any other professional?

2. Did you take medication, or use drugs or alcohol more than once for the problems which occurred as a result of it?

3. Did the problems which occurred as a result of it interfere with your life or activities a lot?

K44 Have you ever been very upset with yourself for having the problems which occurred as a result of (EVENT)?

K45 Have the problems which occurred as a result of (EVENT)

ever kept you from going to a party, social event or meeting?

NO ......... ......................... ❑

YES........ (SKIP TO 2) ..... ❑

NO .................................❑

YES ...............................❑

NO .................................❑

YES ...............................❑

NO .................................❑

YES ...............................❑

NO .................................❑

YES ...............................❑

NO .................................❑

YES ...............................❑

**END OF MODULE – RETURN TO CIDI INTERVIEW**

**EATING DISORDERS**

|  |  |  |
| --- | --- | --- |
| H1 | Now I'd like to ask you about problems you might have | NO ......................................❐ |
|  | had either with eating or with your weight. Have you ever had a concern about your weight, your eating, or being too fat? | YES ....................................❐ |

H2 Have you ever lost a lot of weigh,t that is, (15 LBS/6.5 NO ......................................❐ KG) or more, either by dieting or without meaning to, not YES ....................................❐ by having (a baby or) an operation?

H3 Did relatives or friends ever say that you were much too NO ......................................❐

thin or looked like a skeleton? YES ....................................❐

SX = being too thin

H10 Have you ever had a time when you would eat abnormally large amounts of food within a few hours--that is, eat in binges?

A. How long would one of these binges last?

B. What kind of things would you eat during a typical binge?

RECORD: DOES R VOLUNTEER ONLY A MINIMAL AMOUNT OF

FOOD (LIKE ONE YOGHURT OR ONE CHOCOLATE BAR)?

NO (SKIP TO next page) ...❐

YES ....................................❐

minutes

NO ................. ....................❐

YES(SKIP TO next page) ..❐

H11 Have you ever had a period when you went on eating NO (SKIP TO next page) ...❐

binges at least twice a week? YES ....................................❐

A. What is the longest period you have had of eating

binges at least twice a week? weeks

**PSYCHOSES SCREENER**

*The next set of questions are about ideas or experiences people sometimes have.*

**G1**.In the past 12 months, have you felt that your thoughts were being directly interfered with or controlled by another person?

❏ NO ❏ YES

1a. If YES, did it come about in a way that many people would find hard to believe, for instance, through telepathy?

❏ NO ❏ YES

**G2**.In the past 12 months, have you had a feeling that people were too interested in you?

❏ NO ❏ YES

2a. If YES, in the past 12 months, have you had a feeling that things were arranged so as to have a special meaning for you, or even that harm might come to you?

❏ NO ❏ YES

**G3**.Do you have any special powers that most people lack?

❏ NO ❏ YES

3a. If YES, do you belong to a group of people who also have these powers?

❏ NO ❏ YES

**G4**.Has a doctor ever told you that you may have schizophrenia?

❏ NO ❏ YES

**Interviewer remained blinded to Gulf War status**

❏ **YES** ❏ **NO**

If NO, please indicate in which module (eg. PTSD 2, Alcohol Use etc) Gulf

War status was revealed

PSYCHOLOGIST'S NOTES.

**DOCTOR’S EXAMINATION**

**Section 1: PHYSICAL EXAMINATION**

**Interviewer code**

|  |  |  |  |
| --- | --- | --- | --- |
| **Thyroid** | | | |
| Size | ❏ Normal | ❏ Large |  |
| Tenderness | ❏ No | ❏ Yes |  |
| Nodules | ❏ Absent | ❏ Solitary | ❏ Multiple |

**Cardiovascular system**

Radial pulse Radial pulse rate Precordial impulse Abnormal sounds Murmur(s)

Carotid pulses

Bruit(s)

Pitting oedema Dorsalis pedis pulse Posterior tibial pulse Lower limb skin

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ❏ No | ❏ Yes, ankle | | ❏ Yes, pretibial | |  |
| ❏ Normal | ❏ Reduced R | | ❏ Reduced L | |  |
| ❏ Normal | ❏ Reduced R | | ❏ Reduced L | |  |
| ❏ Normal | ❏ Pallor | ❏ Cyanosis | | ❏ Erythema | ❏ Inflammation |

Varicose leg veins

Other cardiovascular abnormalities

❏ Regular ❏ Irregular

beats per minute

❏ Normal ❏ Abnormal, describe

❏ No ❏ Yes, describe

❏ No ❏ Yes, describe

❏ Normal ❏ Reduced R ❏ Reduced L

❏ None ❏ Yes, R carotid ❏ Yes, L carotid

❏ Other,

❏ No ❏ Yes, R ❏ Yes, L

❏ No ❏ Yes

If YES, describe

**Respiratory System**

Pharyngitis ❏ No ❏ Yes

Tonsils ❏ Normal ❏ Enlarged ❏ Inflamed ❏ Absent

Respiratory rate breaths per minute

Tracheal position ❏ Normal ❏ Deviated to R ❏ Deviated to L Chest excursion ❏ Symmetrical ❏ Decreased R ❏ Decreased L

Chest shape ❏ Normal ❏ Deformity, specify Chest expansion ❏ Normal ❏ Fair ❏ Poor

Percussion ❏ Normal ❏ Hyperresonant ❏ Dullness Zones

❏ Other, describe Crepitations ❏ No ❏ Yes

Wheezes ❏ No ❏ Yes

Other respiratory ❏ No ❏ Yes

abnormalities If YES, describe

**Skin and Nails** Inflammatory skin condition (dermatitis

and eczema)

❏ No ❏ Yes

If YES, is the site(s)

❏ Hand/s ❏ Elbow/s

❏ Forearm/s ❏ Head or neck

❏ Knee/s

❏ Other, describe

Psoriasis ❏ No ❏ Yes

If YES, is the site(s)

❏ Hand/s ❏ Elbow/s

❏ Back ❏ Knee/s ❏ Scalp

❏ Other, describe

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Finger nails | ❏ Normal | ❏ Pitting | ❏ Paronychia | ❏ Thickened |
| Toe nails | ❏ Normal | ❏ Pitting | ❏ Paronychia | ❏ Thickened |

Skin lesion(s) suggestive of skin cancer(s)

Solar keratoses

Acne

Skin Infections

Tattoos (ask)

Other skin/nail

❏ No ❏ Yes

If YES, is the skin lesion(s) suggestive of: (specify site and describe)

❏ Squamous cell carcinoma,

❏ Basal cell carcinoma,

❏ Malignant melanoma,

❏ Other, describe

❏ No ❏Yes

If YES, record site and approximate number

Hand/s ❏ 1-2 ❏ 3-5 ❏ >5

Forearm/s ❏ 1-2 ❏ 3-5 ❏ >5

Head/neck ❏ 1-2 ❏ 3-5 ❏ >5

Other ❏ 1-2 ❏ 3-5 ❏ >5

If other, describe site

❏ No ❏ Yes

If YES, is the site(s) ❏ Face ❏ Back ❏ Other

If other, please specify

❏ No ❏ Tinea ❏ Boils ❏ Other,

❏ No ❏ Yes

❏ No ❏ Yes, describe

abnormalities

**Gastrointestinal System**

|  |  |  |  |
| --- | --- | --- | --- |
| Oral hygiene | ❏ Good | ❏ Fair | ❏ Poor |
| Gingivitis | ❏ No | ❏ Yes |  |
| Mouth Ulcers | ❏ No | ❏ Yes |  |
| Oral plaques | ❏ No | ❏ Yes |  |
| Glossitis | ❏ No | ❏ Yes |  |
| Hepatomegaly | ❏ No | ❏ Yes |  |
| Splenomegaly | ❏ No | ❏ Yes |  |
| Kidney enlargement | ❏ No | ❏ Yes, R | ❏ Yes, L |
| Abdominal mass | ❏ No | ❏ Yes |  |

Hernias ❏ None ❏ R Inguinal ❏ L Inguinal

❏ Other, describe Other ❏ No ❏ Yes, describe

gastrointestinal abnormalities

|  |  |  |  |
| --- | --- | --- | --- |
| **Lymph Nodes** |  | | |
| Epitrochlear | ❏ Normal | ❏ Enlarged | ❏ Tender |
| Cervical | ❏ Normal | ❏ Enlarged | ❏ Tender |
| Supraclavicular | ❏ Normal | ❏ Enlarged | ❏ Tender |
| Axillary | ❏ Normal | ❏ Enlarged | ❏ Tender |
| Inguinal | ❏ Normal | ❏ Enlarged | ❏ Tender |

Other abnormality ❏ No ❏ Yes, describe

**Musculoskeletal system**

|  |  |  |  |
| --- | --- | --- | --- |
| Amputations  Spinal abnormality | ❏ No  ❏ No | ❏ Yes, describe  ❏ Yes, describe | |
| **Joints** |  |  | |
| R-shoulder L-shoulder R-elbow  L-elbow R-wrist L-wrist  R-thumb L-thumb R-fingers L-fingers R-hip  L-hip  R-knee L-knee R-ankle L-ankle | ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal | ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM  ❏ Decreased ROM | ❏ Swelling  ❏ Swelling  ❏ Swelling  ❏ Swelling  ❏ Swelling  ❏ Swelling  ❏ Swelling  ❏ Swelling  ❏ Swelling  ❏ Swelling  ❏ Swelling  ❏ Swelling  ❏ Swelling  ❏ Swelling |

Straight leg raising

|  |  |  |  |
| --- | --- | --- | --- |
| RT | ❏ Normal | ❏ Limited by back pain | ❏ Limited by thigh/leg pain |
| ❏ Limited by muscle stiffness | | | |
| LT | ❏ Normal | ❏ Limited by back pain | ❏ Limited by thigh/leg pain |
| ❏ Limited by muscle stiffness | | | |

Muscular or tendon abnormality

Other musculoskeletal abnormalities

❏ No ❏ Yes, describe

❏ No ❏ Yes, describe

**Neurological System**

**Cranial Nerves**

Sense of smell (ask) ❏ Normal ❏ Abnormal

Ptosis RT ❏ Absent ❏ Present

LT ❏ Absent ❏ Present

Visual Fields ❏ Normal ❏ Abnormal If ABNORMAL, indicate quadrants involved: RT LT

❏ Superior Nasal ❏ Superior Nasal

❏ Inferior Nasal ❏ Inferior Nasal

❏ Superior Temporal ❏ Superior Temporal

❏ Inferior Temporal ❏ Inferior Temporal

Neglect ❏ No ❏ R neglect ❏ L neglect

Diplopia ❏ No ❏ Yes, indicate at which point diplopia is maximal

RT LT

❏ ❏

❏ ❏ ❏

❏ ❏

At the point of maximal diplopia, when does the outer image disappear?

❏ R eye covered ❏ L eye covered

Pupil size ❏ Same ❏ Different

If DIFFERENT, which pupil is bigger ❏ R ❏ L

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | LT | ❏ Normal | ❏ Sluggish | | ❏ None |
| Consensual pupil | RT | ❏ Normal | ❏ Sluggish | | ❏ None |
| reaction | LT | ❏ Normal | ❏ Sluggish | | ❏ None |
| Eyes |  |  |  | |  |
| • Cataract | ❏ No | ❏ Yes, R | | ❏ Yes, L | |
| • Pterygium  • Conjunctivitis | ❏ No  ❏ No | ❏ Yes, R  ❏ Yes, R | | ❏ Yes, L  ❏ Yes, L | |

❏ Other, describe

|  |  |  |  |
| --- | --- | --- | --- |
| Optic discs | RT | ❏ Normal | ❏ Atrophy ❏ Papilloedema ❏ Other |
|  | LT | ❏ Normal | ❏ Atrophy ❏ Papilloedema ❏ Other |

Facial Sensation

Corneal reflex

RT ❏ Normal ❏ Reduced

LT ❏ Normal ❏ Reduced

If reduced, is the site ❏ forehead ❏ malar ❏ mandibular

RT ❏ Present ❏ Absent

LT ❏ Present ❏ Absent

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Eye lid closure | RT | ❏ Normal | ❏ Weak | ❏ Absent |
|  | LT | ❏ Normal | ❏ Weak | ❏ Absent |

Smile

Sternomastoid power

RT ❏ Normal ❏ Weak ❏ Absent

LT ❏ Normal ❏ Weak ❏ Absent

RT ❏ Normal ❏ Weak ❏ Absent

LT ❏ Normal ❏ Weak ❏ Absent

Trapezius power RT ❏ Normal ❏ Weak ❏ Absent

LT ❏ Normal ❏ Weak ❏ Absent

Tongue RT ❏ Normal ❏ Weak

LT ❏ Normal ❏ Weak

|  |  |  |
| --- | --- | --- |
| **Handedness** (ask) | ❏ Right | ❏ Left |
| **Muscle wasting** | ❏ No | ❏ Yes |

If YES, is wasting generalised ❏ No ❏ Yes

localised ❏ No ❏ Yes, specify

**Muscle** ❏ No ❏ Yes

**fasciculations** If YES, are fasciculations generalised ❏ No ❏ Yes

localised ❏ No ❏ Yes, specify

|  |  |  |  |
| --- | --- | --- | --- |
| **Muscle tremor** | RT | ❏ No | ❏ Yes |
|  | LT | ❏ No | ❏ Yes |

If YES, is tremor present at rest? ❏ Yes ❏ No

If NO, describe

|  |  |  |  |
| --- | --- | --- | --- |
| **Muscle tone** |  | | |
| Upper limb | RT ❏ Normal | ❏ Increased | ❏ Decreased |
|  | LT ❏ Normal | ❏ Increased | ❏ Decreased |
| Lower limb | RT ❏ Normal | ❏ Increased | ❏ Decreased |
|  | LT ❏ Normal | ❏ Increased | ❏ Decreased |

**Muscle power** Scale

5 = Normal 4 = Movement with gravity but less than full power

3 = Movement with gravity 2 = Movement without gravity

1 = Visible contraction 0 = No movement

*Please tick the appropriate rating score (5 - 0) for each muscle group*

**RT LT**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **5** | **4** | **3** | **2** | **1** | **0** | **5** | **4** | **3** | **2** | **1** | **0** |
| Shoulder abduction | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |
| Elbow flexion | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |
| Elbow extension | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |
| Brachioradialis | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |
| Wrist flexion | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |
| Wrist extension | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |
| Finger flexion | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |
| Finger extension | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |
| Finger abduction | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |
| Thumb abduction | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ | ❏ |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Hip flexion  Hip extension Knee flexion Knee extension  Ankle dorsiflexion Ankle plantarflexion Ankle inversion Ankle eversion  Toe flexion Toe extension **Reflexes** Biceps | **5**  ❏  ❏  ❏  ❏  ❏  ❏  ❏  ❏  ❏  ❏  RT LT | **RT**  **4 3 2**  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ Normal  ❏ Normal | **1 0**  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ Reduced  ❏ Reduced | | **5 4**  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ ❏  ❏ Absent  ❏ Absent | | **LT**  **3 2 1**  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ ❏ ❏  ❏ Increased  ❏ Increased | **0**  ❏  ❏  ❏  ❏  ❏  ❏  ❏  ❏  ❏  ❏ |
| Triceps | RT LT | ❏ Normal  ❏ Normal | ❏ Reduced  ❏ Reduced | | ❏ Absent  ❏ Absent | | ❏ Increased  ❏ Increased |  |
| Brachioradialis | RT LT | ❏ Normal  ❏ Normal | ❏ Reduced  ❏ Reduced | | ❏ Absent  ❏ Absent | | ❏ Increased  ❏ Increased |  |
| Quadriceps | RT LT | ❏ Normal  ❏ Normal | ❏ Reduced  ❏ Reduced | | ❏ Absent  ❏ Absent | | ❏ Increased  ❏ Increased |  |
| Ankle | RT LT | ❏ Normal  ❏ Normal | ❏ Reduced  ❏ Reduced | | ❏ Absent  ❏ Absent | | ❏ Increased  ❏ Increased |  |
| Plantars  **Coordination**  Finger-Nose Test  Heel-Shin Test | RT LT  RT LT RT LT | ❏ Downgoing  ❏ Downgoing  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal | | ❏ Upgoing  ❏ Upgoing  ❏ Abnormal  ❏ Abnormal  ❏ Abnormal  ❏ Abnormal | | ❏ Equivocal  ❏ Equivocal | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Vibration sense** |  | | |
| Tip of index finger | RT | ❏ Normal | ❏ Decreased |
|  | LT | ❏ Normal | ❏ Decreased |
| Tip of big toe | RT | ❏ Normal | ❏ Decreased |
|  | LT | ❏ Normal | ❏ Decreased |

If NORMAL, proceed to test position sense

If DECREASED, test and record proximally for respective limb(s)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Distal radius Olecranon process Medial malleolus Patella  Ant. sup. iliac spine | RT LT RT LT RT LT RT LT RT  LT | ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal  ❏ Normal | ❏ Decreased  ❏ Decreased  ❏ Decreased  ❏ Decreased  ❏ Decreased  ❏ Decreased  ❏ Decreased  ❏ Decreased  ❏ Decreased  ❏ Decreased |  | |
| **Position sense**  Index finger | RT | ❏ Normal | ❏ Decreased |  |  |
| Big toe | LT RT  LT | ❏ Normal  ❏ Normal  ❏ Normal | ❏ Decreased  ❏ Decreased  ❏ Decreased |  |  |
| **Sensation** (pinprick)  Thumb | RT | ❏ Normal | ❏ Decreased | ❏ Absent | ❏ Hyperpathic |

(C6 dermatome)

LT ❏ Normal ❏ Decreased ❏ Absent ❏ Hyperpathic

Little finger

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| RT | ❏ Normal | ❏ Decreased | ❏ Absent | ❏ Hyperpathic |
| LT  RT | ❏ Normal  ❏ Normal | ❏ Decreased  ❏ Decreased | ❏ Absent  ❏ Absent | ❏ Hyperpathic  ❏ Hyperpathic |

(C8 dermatome)

Nipple level

(T6 dermatome)

LT ❏ Normal ❏ Decreased ❏ Absent ❏ Hyperpathic

Umbilicus level RT ❏ Normal ❏ Decreased ❏ Absent ❏ Hyperpathic

(T10 dermatome)

LT ❏ Normal ❏ Decreased ❏ Absent ❏ Hyperpathic

Big toe RT ❏ Normal ❏ Decreased ❏ Absent ❏ Hyperpathic

(L5 dermatome)

LT ❏ Normal ❏ Decreased ❏ Absent ❏ Hyperpathic

Little toe RT ❏ Normal ❏ Decreased ❏ Absent ❏ Hyperpathic

(S1 dermatome)

LT ❏ Normal ❏ Decreased ❏ Absent ❏ Hyperpathic

|  |  |  |
| --- | --- | --- |
| **Gait** |  | |
| Romberg’s test | ❏ Negative | ❏ Positive |
| Tandem gait | ❏ Normal | ❏ Abnormal |
| Walk on heels | ❏ Normal | ❏ Abnormal |
| Walk on toes | ❏ Normal | ❏ Abnormal |
| Arise from squat,  no use of arms | ❏ Yes | ❏ No |

Other neurological ❏ No ❏ Yes, describe

abnormalities

**General comments:**

**Section 2: SYMPTOMS OF TIREDNESS OR FATIGUE**

*INSTRUCTIONS: Read the questions to the participant. Please tick the most appropriate response, or record month and year where appropriate. If the person cannot remember the month, please record “99” for month and record the year. If the participant asks for clarification of the term “extreme tiredness or fatigue” in responding to the initial questions, this could be clarified as “significantly more than usually experienced in everyday life”. “Months in total” means the aggregate total number of months the extreme tiredness or fatigue was experienced.*

1. In the past 12 months, have you experienced extreme tiredness or fatigue ❏ ❏

following your normal activities?

**If NO, go to Section 3**

NO YES

2. In the past 12 months, have you felt extremely tired or fatigued following your ❏ ❏

normal activities every day, or almost every day, for one month or longer? NO YES

**If NO, go to Section 3**

3. When did this feeling of being extremely tired or fatigued first begin?

*(Record month and year)* /

*4.* When did you last experience this feeling of being extremely tired or fatigued?

*(Record the month and year. If still present, record the current month and year. \*NOTE –If this date is not in the last 12 months, please check the person’s previous responses. If confirmed*

*as not experienced in last 12 months, go to Section 3 – otherwise continue with Q5.)*

/

5. Has/was this feeling of being extremely tired or fatigued present continuously over ❏ Present

this period or did it tend to relapse and recur? continuously

(go to Q6)

❏ Relapsed and recurred (go to Q7)

6. Was the level of severity of the extreme tiredness or fatigue constant over this ❏ Constant

period or did it tend to fluctuate? *(Record response and go to Q10)*

❏ Fluctuated

7. How many months in total have you experienced this extreme tiredness or fatigue? months

8. What was the longest period of time you experienced it for? months

9. When did this longest period of time begin? *(Record month and year)*

/

**10. DOCTOR TO RECORD ON BASIS OF ABOVE RESPONSES:**

**Has this person had a period(s) of extreme tiredness or fatigue that has been** ❏ ❏

**persistent, relapsing or recurring for at least 6 months or more since it first began? NO YES**

**If NO, go to Section 3**

**If YES, continue with Question 11**

**INSTRUCTIONS:** *Please ask the following questions in the present tense if the person is still experiencing extreme tiredness or fatigue, or in the past tense if they are not (see response to Q4).*

*For Questions 13 to 18, please tick the most appropriate category according to the person’s response. If the person is unsure about how to respond, the response categories may be read out to them as a prompt.*

*NOTE: Ask those who have experienced a relapsing and recurring course to consider the aggregate periods of tiredness or fatigue as a whole when answering Questions 11-19.*

11. Have you seen a medical doctor about this extreme tiredness or fatigue? ❏ NO ❏ YES If YES, what was the month and year first seen? *(Record month and year)* / /

Did the doctor find a cause?

❏ NO ❏ YES

If YES, please specify cause if known

12. Does (did) this extreme tiredness or fatigue interfere with your normal activities?

For example, has it interfered with your personal, social, family, work or study ❏ NO ❏ YES

activities?

13. What percentage of your normal personal, social, family, work or study activities are you (were you)

able to do during these period(s) of extreme tiredness or fatigue*?*

❏ <10% ❏ 50 - <75%

❏ 10 - <25% ❏ 75 – 99%

❏ 25 - <50% ❏ 100%

14. Do you (did you) feel extremely tired or fatigued for hours or days following

activities that previously would have been easy for you? ❏ NO ❏ YES

15. If you rest, sleep or relax what happens to this feeling of extreme tiredness or fatigue?

❏ Recover completely or almost completely ❏ Worse

❏ Some recovery ❏ Don't Know

❏ No recovery

16. Does this (did this) extreme tiredness or fatigue happen after physical tasks or mental tasks or both?

❏ Physical tasks ❏ Both physical and mental tasks

❏ Mental tasks ❏ Don’t Know

17. If you could think back to when this extreme tiredness or fatigue first started, over what period of time did it come on?

❏ Hours ❏ Months

❏ Days ❏ Don't Know

❏ Weeks

18. Can you remember any particular illness, injury or event which happened in the

days or weeks before this extreme tiredness or fatigue first started? ❏ NO ❏ YES

If YES, was it:

❏ A cold or flu-like illness ❏ Other infection, specify

❏ Glandular fever ❏ An accident or injury, specify

❏ Don’t know ❏ An emotional/stressful event, specify

❏ Other, please specify

*19.* **INSTRUCTIONS** *The following questions relate to symptoms that the person may have experienced DURING the period(s) of extreme tiredness or fatigue. Ask those who have experienced a relapsing and recurring course to consider the aggregate periods of tiredness or fatigue as a whole when responding. Ask about one symptom (a – h) at a time, and record the responses in the table.*

**For symptoms a - h, ask the person if at any time during the period(s) of tiredness or fatigue***:*

- *they experienced the symptom, and if YES ask*

- *was the symptom mild, moderate or severe*

- *when did it start (record month and year), and*

- *how long it was present for (i.e. the total duration of time it was present for. For a relapsing or*

*recurring course, record the aggregate total number of months).*

**When you have completed questions for symptoms a – h,** *for symptoms that were present for at least 6 months in total duration, ask whether they were present at the same time, i.e. concurrently, for at least 6 consecutive months? You will need to name the specific symptoms you are asking about. If necessary, ask the person to consider the presence of symptoms over the period of most severe tiredness or fatigue.*

*Tick the far column for symptoms that were present at the same time for at least 6 consecutive months.*

*e.g. If headache, sore throat, joint pains and poor memory were all present for at least 6 months, ask “Were any of your symptoms of headache, sore throat, joint pains and poor memory present at the same time for*

*at least 6 consecutive months?” If all were, tick the far column for all four symptoms.*

**SYMPTOM Don’t**

**Know**

**NO**

**Mild**

**YES**

**Moderate Severe**

**STARTED**

**Month/Year**

**TOTAL DUR’N**

**months**

|  |
| --- |
| **Present at same time for at least 6 consecutive months** |
|  |
| ❏ |
| ❏ |
| ❏ |
| ❏ |
| ❏ |
| ❏ |
| ❏ |
| ❏ |

a. Persisting sore throat ❏ ❏ ❏ ❏ ❏

\_ \_ / \_ \_ \_ \_

\_ \_ \_

b. Swollen or painful glands in neck or armpit

❏ ❏ ❏ ❏ ❏

\_ \_ / \_ \_ \_ \_

\_ \_ \_

c. Muscular aches and pains ❏ ❏ ❏ ❏ ❏

\_ \_ / \_ \_ \_ \_

\_ \_ \_

d. Joint aches or pains in several joints

❏ ❏ ❏ ❏ ❏

\_ \_ / \_ \_ \_ \_

\_ \_ \_

e. Poor memory or concentration ❏ ❏ ❏ ❏ ❏

\_ \_ / \_ \_ \_ \_

\_ \_ \_

f. Headaches that were different to any you experienced before the start of this “tiredness”

g. Generally sick, unwell or "off color” for more than 24 hours after exerting yourself

h. Waking up feeling unrefreshed after your usual amount of sleep

❏ ❏ ❏ ❏ ❏

❏ ❏ ❏ ❏ ❏

❏ ❏ ❏ ❏ ❏

\_ \_ / \_ \_ \_ \_

\_ \_ / \_ \_ \_ \_

\_ \_ / \_ \_ \_ \_

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**Section 3: REVIEW OF REPORTED MEDICAL CONDITIONS**

*INSTRUCTIONS: Please review the Medical Conditions section of the* **postal questionnaire (G21 and G22),** *and check that this section has been fully completed. If it hasn’t been fully completed, please ask the participant to do so now.*

*Ask further questions about each “YES” response for the medical problems or conditions to determine whether it was diagnosed or treated by a medical doctor; and if it was, what was the likelihood of the diagnosis. Record one of the following codes in the “office use only” column on the right hand side of the table(s)*. *You should only need to ask a maximum of 3 – 4 questions for each medical problem or condition. You should not be taking a full history. If, after 3 – 4 questions, you are still not sure record a “3”.*

Record reported medical conditions as:

**1 = Non-medical diagnosis**

Condition was not diagnosed or treated by a medical doctor.

**2 = Unlikely diagnosis**

Condition was mentioned by a doctor, perhaps as a possible diagnosis, but:

• person’s history of the condition is not consistent with the diagnosis, and/or

• diagnosis was not confirmed by investigation and treatment was not required.

**3 = Possible diagnosis**

Condition was mentioned or discussed by a doctor, person may have had investigations and some treatment, but this was not consistent with the level of intervention that one would expect from conventional medical practice for a person with this condition.

**4 = Probable diagnosis**

Condition was diagnosed by a doctor, perhaps with specialist referral, and investigated and treated medically or surgically in a manner consistent with conventional medical practice for a person with this condition.

**Section 4: GENERAL HEALTH QUESTIONS and ADDITIONAL FINDINGS**

*INSTRUCTIONS: Ask an open question about the person’s general health and any other health*

*concerns he or she wants to raise. Ask more specific questions if you think it is necessary, particularly for significant concerns that may require urgent follow-up. Record your significant concerns and additional findings in the spaces below for reference in preparing your report.*

*IMPORTANT: If a problem is mentioned here, or in the Medical Conditions section of the postal questionnaire, that you have not been aware of and needs further physical examination, proceed with this re-examination. Record these additional examination findings in the space provided (for consideration in your medical report and by the researchers) but DO NOT alter your previously recorded physical examination findings.*

**“Is there anything else about your health that you would like to raise that we haven’t discussed so far?”**

**1.**

**2.**

**3.**

**4.**

**Notes on significant concerns where a review of the relevant system was thought necessary**

**ADDITIONAL PHYSICAL EXAMINATION FINDINGS**

**Have any conditions come to your attention through the open questions, or review of medical conditions or relevant systems, that required you to carry out a further physical examination?**

❏ **NO** ❏ **YES**

**If YES, please list any additional physical findings here:**

|  |  |
| --- | --- |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

**Section 5: QUEEN’S COLLEGE STEP TEST**

**Is this person fit to perform a brief fitness test? (see table below)**

❏ **YES** ❏ **NO**, please specify reason

**Fitness criteria for the Step Test**.

Precautions: Testing facilities must have appropriate resuscitation equipment and tests supervised by operators trained in CPR. Candidates should be carefully screened for any contraindications.

**Absolute Contraindications**

• Ischaemic Heart Disease

• Unstable angina

• Aortic Stenosis

• Uncontrolled hypertension

• Uncontrolled asthma

• Epilepsy

• Respiratory failure

**Relative Contraindications**

• Participant older than 50

• Currently pregnant, or childbirth in previous three months

• Surgery in previous three months

• Systolic blood pressure greater than 150

• Diastolic blood pressure greater than 95

• History of heart disease

• Treating physician's advice not to exercise

• Musculoskeletal problem likely to be aggravated by the exercise

• Any other reason given by the participant for not doing the test

**Procedure (see Procedure Manual for full details)**

*INSTRUCTIONS:* Set the metronome to 96 BPM for men and 88 BPM for women. After stepping for 3 minutes, read the pulse monitor within 5 seconds of stopping and again 15 seconds later. Please record both readings.

If the participant feels any discomfort, or if the person can not keep up with the metronome (after encouragement), the test should be stopped. The duration of the test, the reason for stopping, and both pulse rate readings should be recorded.

Pulse rate per minute within 5 seconds of stopping test.

Pulse rate per minute 15 seconds after the first reading. Did the person stop before three minutes ❏ **YES** ❏ **NO**

If YES, specify:

• duration of test minutes seconds

|  |  |  |
| --- | --- | --- |
| • reason for stopping | ❏ fatigue | ❏ pain, specify site |
|  | ❏ short of breath | ❏ other, specify |

Note: The average of the two pulses is used as an indication of the participant’s fitness rating

(see Procedure Manual for categories)

**Interviewer remained blinded to the Gulf War status**

❏ **YES** ❏ **NO,** please indicate in which section Gulf War status was revealed.

Section

**Has the participant nominated a medical practitioner to whom medical assessment results can be sent, and signed the consent for release?**

❏ **YES** ❏ **NO**

**(see last page of postal questionnaire)**

If the participant nominated a medical practitioner, but did not sign the consent for a copy to be sent to their nominated medical practitioner, please ask them to do so now. The participant may not wish to nominate a medical practitioner, and is not required to do so. However, please take this opportunity for explaining the reasons for nominating a medical practitioner, e.g. The report will provide useful information to their medical practitioner; any abnormalities can be considered in the context of a more complete picture of their health and by someone who is in a better position to arrange appropriate follow- up if necessary. If they do not wish to nominate a medical practitioner, they should not feel pressured to do so.

**Provide immediate verbal feedback on urgent or serious conditions and complete the “URGENT” feedback letter for the participant to take with them to their medical practitioner.**

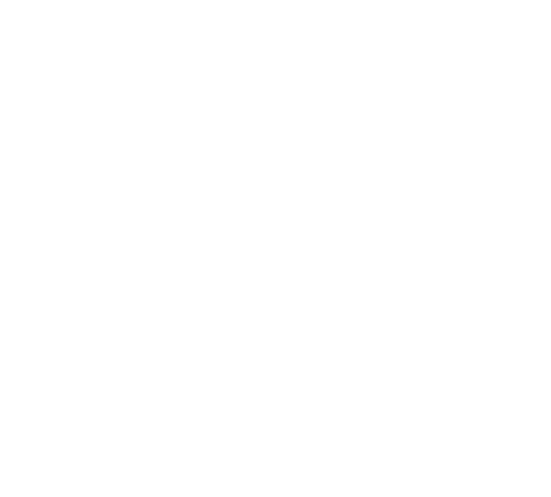
Consider your examination findings and abnormal results of the blood pressure, urinalysis and spirometry tests undertaken by the nurse in providing urgent feedback on urgent or serious conditions to the participant if required. (Guidelines for feedback of spirometry results are included in the Procedure Manual). Complete the “URGENT” letter. Make a photocopy of this letter and attach it to the Data Collection Booklet on page 42. Give the letter to the participant to take with them.

**Please use this sheet for any additional notes you may wish to make.**

DOCTOR'S EXAMINATION

Attach photocopies of all medical letters here

**6. IMVS reference intervals and testing methodology**



**Institute of Medical and Veterinary Science**

The specimens were collected according to specified protocols in the Collection Centres throughout Australia.

The clinical chemistry samples were centrifuged within 4 hours of collection by specified laboratories in each area. The centrifuged clinical chemistry specimens and other specimens (not T cell subsets) were sent in eskies with an ice block by overnight courier transport. The T cell subsets were transported at ambient temperatures. The specimens were delivered to the central IMVS laboratory, Frome Road, Adelaide, South Australia between 0830 – 1000h the following morning.

The current IMVS reference intervals that were used for comparative purposes in the study are detailed in Table 6.1 to Table 6.5.

***Table 6.1 Haematology investigations undertaken within the study, IMVS reference intervals (adults) and testing methods***

**Parameter**

Haemoglobin

Packed Cell Volume

Red Cell Count

Mean Corpuscular Volume

**Reference Interval Method**

**Male Female**

135-175 g/L 115-155 g/L

0.40-0.50 L/L 0.35-0.45 L/L

4.50-6.00 x 1012/L 3.80-5.20 x 1012/L

80.0-98.0 fL

Mean Corpuscular Haemoglobin

Mean Corpuscular Haemoglobin

Concentration

Red cell distribution width White Cell Count Neutrophils

Lymphocytes Monocytes Eosinophils Basophils Platelets

Erythrocyte Sedimentation Rate

27.0-33.0 pg

315-355 g/L

11.5-15.5%

4.0-11.0 x 109/L

1.80-7.50 x 109/L

1.00-3.50 x 109/L

0.20-0.80 x 109/ L

0.02-0.50 x 109/L

0.00-0.10 x 109/L

150-400 x 109/L

1-10 mm 1-12 mm

> 50 yrs

1-15 mm 1-20 mm

Hb and RBC parameters,

Platelets, WBC and differential counts Bayer Technicon H2 analysers and the Sysmex XE 2100 analysers. These two analysers have been fully evaluated one against the other.

Starrsed automated analyser

The assays were controlled by internal quality controls and external quality controls as organised by the RCPA Haematology program.

Routine biochemical analysis (including liver function tests) was performed on Technicon Dax 48 analysers. The assays were controlled by the use of internal quality controls and the External Quality Assurance Program as organised by RCPA/AACB. The laboratory has The National Association of Testing Authorities, Australia (NATA) and AS/NZS ISO9002 accreditation. The reference intervals and the methods used for each analyte are described in Table 6.2 and Table 6.3.

***Table 6.2 Biochemical investigations undertaken within the study, IMVS reference intervals (adults) and testing method***

|  |  |  |
| --- | --- | --- |
| **Analyte** | **Reference Interval** | **Method** |
| Sodium | 137-145 mmol\L | Ion specific electrode |
| Serum Potassium | 3.5-4.9 mmol/L | Ion specific electrode |
| Chloride | 100-109 mmol/L | Ferric perchlorate method |
| Bicarbonate | 22-32 mmol/L | Enzymatic method |
| Anion Gap | 7-17 mmol/L | Calculated entity on the computer utilising (Sodium + potassium) – (Chloride + bicarbonate) |
| Urea | 2.7-8.0 mmol/L | Enzymatic method |
| Creatinine | 0.05-0.12 mmol/L | Jaffe reaction |
| Ionised Calcium | 1.10-1.25 mmol/L | Calculated entity on the computer utilising albumin, globulin and Na, K, Cl, bicarbonate |
| Phosphate | 0.65-1.45 mmol/L | Molybdate method |
| Random blood glucose | \* | Hexokinase method |
| C-Reactive Protein | <4-10 mg/L | Beckman Immage nephelometric method |

\* IMVS does not report a reference interval for a random blood glucose. To compare study groups, the criteria used and the interpretation

of these are those recently recommended by the NHMRC (<http://www.health.gov.au/nhmrc/advice/pdf/type2.pdf>)

***Table 6.3 Liver function tests undertaken within the study, IMVS reference intervals***

***(adults) and testing methods***

|  |  |  |
| --- | --- | --- |
| **Liver function tests** | **Reference interval** | **Method** |
| Albumin | 34-48 g/L | Bromocresol purple method |
| Globulin | 26-41 g/L | Calculated by difference of albumin from total protein |
| Protein | 65-85 g/L | Biuret method |
| Total Bilirubin | 6-24 µ mol/L | Diazo method |
| Gamma-Glutamyl-Transferase  (GGT) | 0–60 U/L | IFCC recommended method |
| Alkaline Phosphatase (ALP) | 30-110 U/L | IFCC recommended method |
| Alanine Aminotransferase (ALT) | 0–55 U/L | IFCC recommended method |

|  |  |  |
| --- | --- | --- |
| **Liver function tests** | **Reference interval** | **Method** |
| Aspartate Aminotransferase (AST)  Lactate Dehydrogenase (LD) | 0–45 U/L  110-230 U/L | IFCC recommended method  Lactate to pyruvate method |

The reference intervals and testing methods for the virology and immunological parameters investigated in the study are described in Table 6.4and Table 6.5.

***Table 6.4 Virology tests undertaken within the study, IMVS reference intervals (adults)***

***and testing methods***

|  |  |  |
| --- | --- | --- |
| **Parameter** | **Reference interval** | **Method** |
| EBV IgG antibody | Not detected, �sample < 0.100  Detected, �sample >0.200  Equivocal, 0.100 - 0.200 | Dade Behring Enzygnost |
| CMV IgG antibody | Detected, >15 antibody units/ml (AU/ml) | Abbott AxSym analyser |
| Not detected, <10 AU/ml | | |
| Equivocal, 10-15 AU/ml | | |
| Hepatitis C antibody | Negative, S/CO < 1.00 | Abbott AxSym HCV version 3.0 MEIA |
| Positive, S/CO >= 1.00 | | |
| Indeterminate, S/CO 0.80-0.99 | | |

***Table 6.5 Immunology tests (lymphocyte subpopulations) undertaken within the study, IMVS reference intervals (adults) and testing methods***

**Reference intervals Method**

**Parameter**

**T cell markers**

CD3

CD4+CD3+ CD8+CD3+ CD4/CD8 ratio **B cell markers** CD19

**Natural Killer Cell markers**

CD16+CD3- CD56+CD3- CD16+/CD56+CD3-

**Percentage of Cell count (x 109/L)**

**lymphocytes (%)**

44-90 % 0.66-3.22 x 109/L

27-63 % 0.41-2.21 x 109/L

11-38 % 0.17-1.33 x 109/L Flow cytometry on the ratio 0.72-3.6 lysis Q prep method

Coulter. Whole blood

using Coulter reagents

2-15 % 0.30-0.53 x 109/L

not reported not reported not reported not reported.

1-13 % 0.15-0.46 x 109/L

7. Ethics Committees' Approvals

X



CP2-7-66 Department of Defence CANBERRA ACT 2600

PE 2000/646411

ADMEC 208/00

DHSB -:::k,-f /2000

**DrM Sim**

Department of Epidemiology and Preventive Medicine

Monash Public Health Monash Medical School Alfred Hospital

Prahran, Victoria 3181

Dear Dr Sim

**AUSTRALIAN DEFENCE MEDICAL ETHICS COMMITTEE (ADMEC) PROTOCOL 208/00: GULF WAR VETERANS HEALTH STUDY**

I. Thank you for providing the requested amendments to your protocol. ADMEC has now cleared your project to proceed. Please note that ethical clearance from ADMEC does not automatically confer access to ADF personnel; this will have to be sought from the relevant military commanders.

2. Your protocol has been allocated ADMEC Protocol Number 208/00, and this number should be quoted in all correspondence. Six-monthly progress reports are required, the first being due on 20 July 2001 . ADMEC's compliance with the NHMRC National Statement on Ethical Conduct in Research Involving Humans requires that your progress reports include. where applicable, comment on: the security of your records: compliance with the approved consent procedures and documentation. and compliance with any other special conditions that ADMEC may have required.

3. For completeness. would you please sign the enclosed researcher's agreement and return it to me at your convenience. I have also enclosed ADMEC's Guidelines for Volunteers, a copy of which is to be given to each study participant.

4. The Committee wishes you well with your research. Please contact me if I can be of any assistance.

Yours sincere]y.

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**M. BLENKIN**

Lieutenant Commander

Executive Secretary



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VETERANS' AFFAIRS

:--JAr roNAL OFFICE

A/Professor Malcolm Sim

Principal Investigator

Gulf War Veterans' Health Study

Monash Medical School

Alfred Hospital

Prahran Victoria 3181

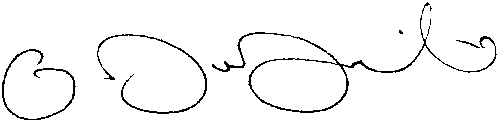
Dear Professor Sim

Gulf War Veterans' Health Study

Thank you for submitting further information addressing privacy issues raised by the DVAHRE Committee. The Committee agreed in February :2000 that the revised study protocol should be resubmitted to the Committee coordinator for final consideration by the Chairman.

The Chairman has considered the revised protocol and the privacy issues addressed in your letter to the Committee coordinator. dated 20 December 2000. He endorses the continuation of the project.

Please note that the Committee should be advised immediately in writing if the protocol changes from that approved. and before the study progresses under the amended protocol. This is part of the Committee's monitoring role.



Additionally. it is a requirement that researchers provide the Committee with progress reports or a final report for shorter-term projects. The Committee looks forward to receiving your progress/final report in due course.

Please do not hesitate to contact me with any further questions on (02) 6289 6280.

Georgina Dudzinski

DVA Human Research Ethics Committee Coordinator

10 January 2001

cc: Dr Keith Horsley. Medical Services Adviser, Compensation and Support. DV *A*

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M 0 N A s H u N I v E R s I T y

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8 May 2000

Assoc. Professor Malcolm Sim Epidemiology and Preventive Medicine Monash University Medical School Alti·ed Campus

Project 2000/140- Gulf war veterans health study

Thank you for the information provided in relation to the above project. The items requiring attention have been resolved to the satisfaction of the Committee. The project has now been approved as conforming to the NHMRC guidelines.

!"he project is approved as submitted for a three year period and this approvai is oniy vaiid whilst you hold a position at Monash University. You should notify the Committee immediately of any adverse effects on participants or unforeseen events and seek approval for any proposed changes. Should you \Vish to adapt this project to other circumstances, you can apply for an extension or variation to the original protocol. However, substantial variations may require a new application. Please quote the project number above in any further correspondence and include it in the complaints clause:

*Should you have any complaint concerning the manner in which this research (prf!ject number........) is conducted, please do not hesitate to contact The Standing Committee on Ethics in Research Involving l!umans at thefolhnl'ing address:*

*The Secretary*

*The Standing Committee on Ethics in Research Involving flumans*

*PO Box No 3A Monash University Victoria 3800*

*Telephone ((}3) 9905 2052 Fax (03) 9905 1420*

*}<\_'mail: SCERH(ij;adm. monash. edu.au*

Human Research Ethics Committees are required by the NHMRC to monitor research projects until completion to ensure that they continue to conform with approved ethics standards. Continued approval of this project is dependent on the submission of annual progress reports and a termination report. Please ensure that the Committee is provided with an annual report and a brief summary oft he outcomes of your project when it has concluded. The report form is available at [http://www.monash.edu.au/resgrant/h\_a\_ethics/human\_cthics.](http://www.monash.edu.au/resgrant/h_a_ethics/human_cthics)

The Chief Investigators of approved projects are responsible for the storage and retention of original data pe1taining to a project for a minimum period of five years. You are requested to comply with this requirement.

Ann Michael

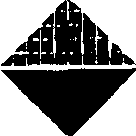
Human Ethics Officer

Standing Committee on Ethics in Research Involving Humans

**f\LE COPl**

Date of Meeting: *n* August 2001

**AIHW** AUSTII.ALIAN INSTITUTE OF HEALTH & WELfARE



*The* Chairperson

Australian Jnstitute of Health and Welfare

Title of Activity: AUSTRALIAN GULF WAR VETERAN'S HEALTH STUDY

Submitted by:

Ethics Committee

Register Number:

Mr John Harding

EC 280

The Ethics Committee is of the opinion that this activity as described in the written submission held in the Committee's records (01/ 471) at this date is acceptable on ethical grounds subject to:

• The codes for accessing a particular participant's files being kept by the Secretary of the DVA Ethics Committee.

• A meeting being held to further discuss the issue of storage of cancer data where approval has not been granted. The result is to be reported to the Ethics Committee.

The Committee needs to be informed of any changes contemplated or made in the conduct of this activity and of any adverse effects or une:.:pected ethical issues *which* arise so that the Committee can fulfil its function of informing the Institute of continuing acceptability on ethical grounds.



The AIHW requests that assistance provided be recognised in all publications and reports resulting from this submission

Signed .

(Mr Robert Todd) Chairman

Australian Institute of Health and Welfare

Ethics Committee

17 September 2001

**F...- luurlt& a.d weHare ncnktlu d ilrt**

cc John Harding

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