

**Telephone Questionnaire
Oklahoma City Bombing Follow-Up Questionnaire**

OSDH # _____
Seq # _____
Beginning Time _____
Ending time _____
DOB _____

Respondent _____ Date of interview ____/____/____
(If different from survivor)

VERIFY PATIENT INFORMATION

Survivor _____ Tel # _____/_____
(Last name, First name) _____/_____

Current Address _____ Zip Code _____

Ask 12 items from health status questionnaire here.

A. BACKGROUND

1. When the bomb exploded, what was your exact location? _____
Bldg _____ Floor _____ Location on floor _____

I will be sending you a map of (*Murrah Bldg, Journal Records, Water Resources or YMCA*) that shows your location when the bomb exploded (*your location will be circled*); please make any corrections to the map you think are necessary. A green postage paid envelope will be included for you to return the map.

2. How close were you to windows?
a. Not close to windows
b. _____ feet

3. What were you doing at the time of the bombing?
 Sitting Standing Bending/stooping Walking Other _____

4. Which direction were you facing?
 North East
 South West Don't know/remember

5. Did you hear the noise of the explosion?
 Yes No Don't know/remember
5a. **(If Yes)** how intense was the noise on a scale of 0 (**no noise**) to 10 (**very intense**), and tell me the number.
(CIRCLE) 0 1 2 3 4 5 6 7 8 9 10

6a. Did you feel any sensations prior to or during the bombing (**pressure in the room, etc**).

6b. What actions did you take immediately after the bombing? (**in as few words as possible**)

7. Were you trapped (**unable or delayed in reaching the outside**) at any time after the bomb exploded?
[]Yes []No (If No, SKIP to #10)

8. About how long were you trapped? _____Hours _____Minutes

9. What caused you to be trapped? (**Check all that apply**)

- []ceilings/walls []furniture/equipment/debris blocked exit
[]door jammed []no physical way to exit
[]body covered by debris/walls/furniture/other _____

10. Did any piece of furniture or equipment prevent collapse of beams, columns, or parts of walls near you?

- []Yes []No []Don't know/remember

(If Yes, specify) _____

11. Did any piece of furniture or equipment protect you from injury?

- []Yes []No []Don't know/remember

(If Yes, specify) _____

12. Did you have assistance evacuating the building? []Yes []No (If No, SKIP to #14)

13. Who provided assistance?

- []Firefighter []Police []Other victims []Don't know/remember
[]Other _____

14. Were you physically injured? (**Includes smoke and dust inhalation, and hearing problems**)

(If Yes) 14a. When were you injured? []when bomb exploded? []when evacuating

(If No, SKIP to #16)

15. Please tell me what type of injuries you had – even if they were minor injuries such as a cut or bruise. At the same time, describe what part of your body was injured, such as your leg, head or back and what caused the injury, such as a piece of glass or wood. I have a figure of a body on paper here and as you describe your injuries, I will be writing these in.

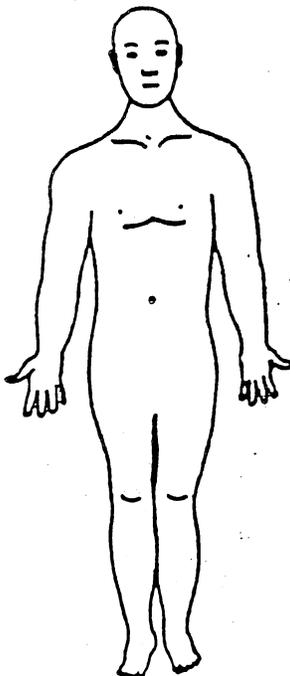
[ATTENTION INTERVIEWER: Please inquire thoroughly about minor injuries such as hearing loss, vision loss, concussion, and TMJ, as well as serious injuries such as internal injuries, severe lacerations, and fractured bones, etc.]

[Complete diagram on next page]

Write/draw in the site of injury as the respondent describes it (and size when possible). Draw a line to the written description of the type of injury and what material caused it.

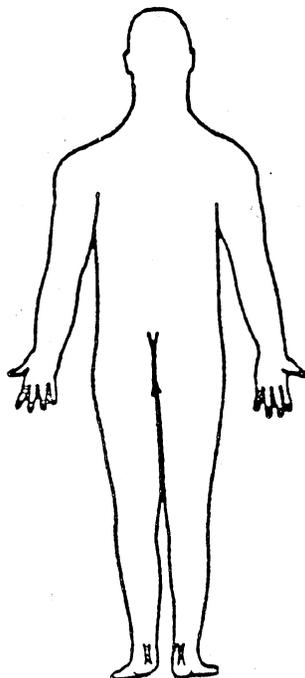
Right

Left



Left

Right



15a. Dust inhalation Yes No
15b. Smoke inhalation Yes No

16. What were you wearing the day of the bombing? (*Read off list as appropriate and check all that apply*)

- | | | |
|---|---|---|
| <input type="checkbox"/>]16a. Shirt/blouse | <input type="checkbox"/>]16a ¹ . Short sleeved | <input type="checkbox"/>]16a ² . Long sleeved |
| <input type="checkbox"/>]16b. Jacket | <input type="checkbox"/>]16b ¹ . Short sleeved | <input type="checkbox"/>]16b ² . Long sleeved |
| <input type="checkbox"/>]16c. Slacks | | |
| <input type="checkbox"/>]16d. Dress | <input type="checkbox"/>]16d ¹ . Short sleeved | <input type="checkbox"/>]16d ² . Long sleeved |
| <input type="checkbox"/>]16e. Skirt | <input type="checkbox"/>]16e ¹ . Short | <input type="checkbox"/>]16e ² . Long |
| <input type="checkbox"/>]16f. Undershirt | | |
| <input type="checkbox"/>]16g. Glasses | Were they blown off? <input type="checkbox"/>]Yes <input type="checkbox"/>]No | |
| <input type="checkbox"/>]16h. Other _____ | | |

17. According to our records, you were: (*per OSDH records/verify with respondents*)

- | | | Date
adm | Date
disc |
|------------------------------|--|-------------|--------------|
| 17a. Hospitalized (2) | <input type="checkbox"/>]Yes <input type="checkbox"/>]No | ___/___/___ | ___/___/___ |
| 17b. Emergency room only (3) | <input type="checkbox"/>]Yes <input type="checkbox"/>]No | | |
| 17c. Private physician (94) | <input type="checkbox"/>]Yes <input type="checkbox"/>]No | | |
| 17d. Not listed (5) | <input type="checkbox"/>]Yes <input type="checkbox"/>]No | | |

B. MEDICAL STATUS

(If the person responds “Yes” to any of the following conditions, ask if he/she had the conditions) before the bombing.)

18. Have you ever been diagnosed or treated by a doctor for any of the following conditions?

| Problem | Since bombing | | Before bombing | | Problem worse? | | Problem resolved? | |
|---------------------------|---------------|-----|----------------|-----|----------------|-----|-------------------|-----|
| | No | Yes | No | Yes | No | Yes | No | Yes |
| 18a. Asthma/bronchitis | [] | [] | [] | [] | [] | [] | [] | [] |
| 18b. Head or brain injury | [] | [] | [] | [] | [] | [] | [] | [] |
| 18c. Depression | [] | [] | [] | [] | [] | [] | [] | [] |
| 18d. Anxiety | [] | [] | [] | [] | [] | [] | [] | [] |
| 18e. Hearing problems | [] | [] | [] | [] | [] | [] | [] | [] |
| 18f. Impaired vision | [] | [] | [] | [] | [] | [] | [] | [] |
| 18g. Other _____ | [] | [] | [] | [] | [] | [] | [] | [] |
| 18h. Other _____ | [] | [] | [] | [] | [] | [] | [] | [] |
| 18i. Other _____ | [] | [] | [] | [] | [] | [] | [] | [] |

C. SELF-REPORTED HEALTH STATUS

(If the person responds “Yes” to having any of the following problems since the bombing, ask if he/she had the problem before the bombing.)

19. Since the bombing, have you experienced any of the following?

| Problem | Since bombing | | Before bombing | | Problem worse? | | Problem resolved? | |
|--|---------------|-----|----------------|-----|----------------|-----|-------------------|-----|
| | No | Yes | No | Yes | No | Yes | No | Yes |
| 19a. Frequent headaches | [] | [] | [] | [] | [] | [] | [] | [] |
| 19b. Dizzy-lightheaded | [] | [] | [] | [] | [] | [] | [] | [] |
| 19c. Ringing/roaring in ears | [] | [] | [] | [] | [] | [] | [] | [] |
| 19d. Trouble hearing | [] | [] | [] | [] | [] | [] | [] | [] |
| 19e. Trouble breathing/catching your breath | [] | [] | [] | [] | [] | [] | [] | [] |
| 19f. Chronic pain | [] | [] | [] | [] | [] | [] | [] | [] |
| 19g. Trouble sleeping | [] | [] | [] | [] | [] | [] | [] | [] |
| 19h. Hopelessness | [] | [] | [] | [] | [] | [] | [] | [] |
| 19i. Difficulty concentrating | [] | [] | [] | [] | [] | [] | [] | [] |
| 19j. Poor memory | [] | [] | [] | [] | [] | [] | [] | [] |
| 19k. Difficulty making choices | [] | [] | [] | [] | [] | [] | [] | [] |
| 19l. Feeling stressed | [] | [] | [] | [] | [] | [] | [] | [] |
| 19m. Trouble with relationships | [] | [] | [] | [] | [] | [] | [] | [] |
| 19n. Feelings of isolation | [] | [] | [] | [] | [] | [] | [] | [] |
| 19o. Difficulty controlling anger | [] | [] | [] | [] | [] | [] | [] | [] |
| 19p. Disturbing dreams | [] | [] | [] | [] | [] | [] | [] | [] |
| 19q. Jumpy or easily startled | [] | [] | [] | [] | [] | [] | [] | [] |
| 19r. Recurring distressful thoughts of bombing | [] | [] | [] | [] | [] | [] | [] | [] |
| 19s. Alcohol or drug use | [] | [] | [] | [] | [] | [] | [] | [] |
| 19t. Other _____ | [] | [] | [] | [] | [] | [] | [] | [] |

20. Overall, are you able to do all of the same things now that you did before the bombing?

[] Yes [] No (If Yes, skip to Socialization and Quality of Life Question, #28)

D. FUNCTIONAL STATUS

(If the person responds "Yes" to having any of the following problems since the bombing, ask if he/she had the problem before the bombing.)

21. Have you had difficulty performing the following activities because of **physical** problems?

| Problem | Since bombing | | Before bombing | | Problem worse? | | Problem resolved? | |
|-------------------------------|---------------|-----|----------------|-----|----------------|-----|-------------------|-----|
| | No | Yes | No | Yes | No | Yes | No | Yes |
| 21a. Walking | [] | [] | [] | [] | [] | [] | [] | [] |
| 21b. Household chores | [] | [] | [] | [] | [] | [] | [] | [] |
| 21c. Dressing and undressing | [] | [] | [] | [] | [] | [] | [] | [] |
| 21e. Working with arms, hands | [] | [] | [] | [] | [] | [] | [] | [] |
| 21f. Driving a vehicle | [] | [] | [] | [] | [] | [] | [] | [] |
| 21g. Other _____ | [] | [] | [] | [] | [] | [] | [] | [] |

Assistance Needed

22. How often do you need assistance in carrying out daily activities such as maintaining the home?

- All the time (*every day*)
- Sometimes
- Never

23. How often did you need assistance in carrying out daily activities such as maintaining the home *before the bombing*?

- All the time (*every day*)
- Sometimes
- Never

24. Do you need any of the following equipment to assist you in performing your daily activities?

- Cane or crutches
- Walker
- Wheelchair
- Prosthesis
- Other _____
- No

25. Did you need any of the equipment to assist you in performing your daily activities before the bombing?

- Cane or crutches
- Walker
- Wheelchair
- Prosthesis
- Other _____
- No

26. Do you need help in handling your daily business or activities outside the home because of any kind of health problem?

- Yes
- No

26a. What is the problem? _____

27. Did you need help in handling your daily business or activities outside the home because of any kind of health problem before the bombing?

- Yes
- No

27a. What is the problem? _____

Quality of Life/Socialization

28. About how often do you take part in leisure activities outside of the home such as movies, sports, and restaurants?

- Never
- 1-4 times a week
- 5 times pr more a week
- 1-3 times a month

29. How many times did you take part in these activities before the bombing?

- Same
- More
- Less

30. How often do you visit friends or relatives outside your home?

- Never
- 1-4 times a week
- 5 times pr more a week
- 1-3 times a month

31. How many times did you visit them *before the bombing*?

- Same
- More
- Less

32. What is your marital status?

- Divorced Separated
- Single Widowed
- Married/Significant other

33. Has your marital status changed during the past 1½ years?

- Yes
- No

33a. If so, how? _____

E. UTILIZATION OF SERVICES

(Frequency and kinds of services utilized since the bombing.)

34. Since the bombing, have you been treated in a hospital, either in the emergency room or admitted?
(Excluding treatment given immediately after the bombing.)

| | Yes | No | Hospital | Date | Reason |
|-----------------------------------|-----|-----|----------|-------------|--------|
| 34a. Emergency room visits | [] | [] | _____ | ___/___/___ | _____ |
| | [] | [] | _____ | ___/___/___ | _____ |
| | [] | [] | _____ | ___/___/___ | _____ |

34a¹ About how many times were you treated in the emergency room during the past 1-½ years?
 ___ times

| | | | | | |
|----------------------|-----|-----|-------|-------------|-------|
| 34b. Hospital | [] | [] | _____ | ___/___/___ | _____ |
| | [] | [] | _____ | ___/___/___ | _____ |
| | [] | [] | _____ | ___/___/___ | _____ |
| | [] | [] | _____ | ___/___/___ | _____ |

| | | | | | |
|---|-----|-----|-------|-------------|-------|
| 34c. Outpatient <i>(procedures)</i> | [] | [] | _____ | ___/___/___ | _____ |
| | [] | [] | _____ | ___/___/___ | _____ |
| | [] | [] | _____ | ___/___/___ | _____ |
| | [] | [] | _____ | ___/___/___ | _____ |

(If the respondent has NOT been treated in a facility for any problems or reported a hearing problem only, then ask the items with an asterisk []).*

35. Have you received any of the following health care services because of problems related to the bombing?

| Service | No | In Pt. | Out Pt. | Name of the Facility/Physician | # of visits | Time Frame |
|---|----|--------|---------|--------------------------------|-------------|------------|
| *35a. Audiologist (hearing) | | | | | | |
| *35b Dental services | | | | | | |
| *35c. Vision services (Excluding routine lens changes) | | | | | | |
| 35d Physical therapy | | | | | | |
| 35e. Occupational therapy | | | | | | |
| 35f. Orthotics/prosthetics | | | | | | |
| 35g. Home health | | | | | | |
| *35h. Psychological counseling | | | | | | |
| *35i. Family counseling | | | | | | |
| *35j. Alcohol or drug treatment | | | | | | |
| 35k. Specialized mobility equipment | | | | | | |
| 35l. Other | | | | | | |
| 35m. Other | | | | | | |

36. About how many times since the bombing have you seen a physician for **physical** problems (**excluding your stay(s) in the hospital**).

- 1-5 11-20
 6-10 More than 20 times Never

37. Were you employed at the time of the bombing? Yes No Retired

37a. If Yes Fulltime Parttime

Specify employer _____

38. Have you been employed any time since the bombing? Yes No

38a. If Yes Fulltime Parttime

Specify employer _____

39. Are you currently employed? Yes No Retired on schedule Early retirement

39a. If Yes Fulltime Parttime

Specify employer _____

(If No, Retired, or Early retirement, the SKIP to G. Medical Care Charges)

40. Approximately what date did you go back to work? Fulltime ____/____/____ Parttime ____/____/____

41. How many hours a week do you work? Fulltime Parttime (# hours _____)

42. Did your employer change as a result of the bombing? Yes No

If Yes, explain _____

43. Did your job change as a result of the bombing? Yes No

44. Do you do a different **type** of work than before the bombing" Yes No

44a. How is it different? _____

45. Do you do the same **amount** of work as before the bombing? Yes No

45b. How is it different? _____

G. ESTIMATED MEDICAL CARE CHARGES FOR INJURED PERSONS SINCE THE BOMBING

46. Could you give a rough estimate of what the total medical care costs have been for your injury?
(I realize that this may be difficult --- the amounts may come from bills you have received or statements from insurance companies. We have several ranges that you may choose from. I'll read them off and you can tell me in which range the costs will fall.)

46a. Under \$1,000

46b. \$1,000 to \$5,000

46c. \$5,000 to \$25,000

46d. \$25,000 to \$50,000

46e. \$50,000 to \$150,000

46f. \$More than \$150,000

46g. No Cost (**Do Not Read This Category**)

46h. Don't Know

47. Do you have any kind of health care coverage such as health insurance, prepaid plans like HMOs, or government plans like Medicare? Yes No

47a. What kind of coverage do you have? _____

48. How have your medical expenses been paid since the bombing? (**Check all that apply**)

- Self Private insurance Medicaid N/A/no medical expenses
 Workmen's Comp Medicare Special Funds
 Not Paid Other _____

49. How have your psychological counseling expenses been paid since the bombing? (**Check all that apply**)

- Self Private insurance Medicaid
 Workmen's Comp Medicare Special Funds
 Not Paid Didn't need Other _____
 Provided no cost

50. Do you need assistance in paying your medical expenses or obtaining services?

- Yes No

(If No and person seems to have a disability, go to question #53; otherwise end the interview.)

51. If there is assistance available related to the bombing, would you be interested in getting assistance?

- Yes No

51a. **(If Yes)** What kind of assistance? _____

52. If you want assistance, may we give your name to an agency that may have assistance?

- Yes No

(If the person seems to have a disability, ASK:)

53. If our records are subpoenaed for the upcoming criminal trials, will you give your permission for us to use your records as testimony?

- Yes No Not sure Other _____ -