

OKLAHOMA CITY CONFIDENTIAL SURVEY OF BOMBING SURVIVORS

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of birth \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_

Where were you when the blast occurred?

- \_\_\_ Away from the downtown Oklahoma City area (Which agency do you work for?) \_\_\_\_\_
\_\_\_ (If you were not in the downtown area, we do not need further information--Thank you.)
\_\_\_ Murrah Building (Which floor were you on?) \_\_\_\_\_ (Which agency do you work for?) \_\_\_\_\_
\_\_\_ Water Resources Building (Which floor were you on?) \_\_\_\_\_
\_\_\_ Journal Record Building (Which floor were you on?) \_\_\_\_\_ (Which agency do you work for?) \_\_\_\_\_
\_\_\_ YMCA (Which floor were you on?) \_\_\_\_\_
\_\_\_ Other location (Specify) \_\_\_\_\_

What types of injuries did you have? (Check all that apply.)

- \_\_\_ Eye injuries
\_\_\_ Hearing problems--Has the condition improved or gone away since the incident? GYes GNo
\_\_\_ Cuts (Where on body?) \_\_\_\_\_
\_\_\_ Did you get stitches? GYes GNo GUnknown
\_\_\_ Glass or metal in skin (Where on body?) \_\_\_\_\_
\_\_\_ Bruises (Where on body?) \_\_\_\_\_
\_\_\_ Broken bone(s) (Which bone(s)?) \_\_\_\_\_
\_\_\_ Strains/sprains (Where on body?) \_\_\_\_\_
\_\_\_ Smoke/dust inhalation
\_\_\_ Psychological or emotional problems
\_\_\_ Other (Specify type of injury/where on body) \_\_\_\_\_
\_\_\_ NO BODILY INJURIES

Were you seen at an emergency room/hospital? GYes GNo GUnknown

If yes, name of hospital(s) \_\_\_\_\_ Date(s) you were seen \_\_\_\_\_
If yes, how were you transported? \_\_\_\_\_

Were you seen by a doctor at an office or clinic? GYes GNo GUnknown

If yes, name of doctor \_\_\_\_\_ Location of office/clinic \_\_\_\_\_
Date you were first seen \_\_\_\_\_ Total number of visits to doctor for these injuries: \_\_\_\_\_

Which of the following contributed to your injuries? (Check all that apply.)

- \_\_\_ Flying glass
\_\_\_ Window blinds
\_\_\_ Falling light fixture
\_\_\_ Falling ceiling
\_\_\_ Other falling debris
\_\_\_ Other (specify) \_\_\_\_\_
\_\_\_ Falling down stories of building
\_\_\_ Falling onto glass or debris
\_\_\_ Being pushed/pulled against something
\_\_\_ Loud noise
\_\_\_ Unknown

Please describe as specifically as possible how these injuries occurred (Example: While leaving the building I fell on glass and cut my hand): \_\_\_\_\_

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

I understand the purpose of this survey is to complete assessment of all physical injuries associated with the bombing and give my consent to participate.

Signature \_\_\_\_\_