



PLEASE ANSWER THE FOLLOWING SUPPLEMENTAL AIRCRAFT-SPECIFIC QUESTIONS

1) Your name: _____ Email: _____

Today's date: _____ Airline (optional): _____

2) Is your blood sample connected to one or more specific smoke/fume event(s)? (circle one) Yes --- No

3) Have you been in one or more fume events in the past, to your knowledge? (circle one) Yes --- No

4) If you are reporting a specific and recent fume event, please answer the following questions:

Aircraft type: _____ Aircraft number: _____

Flight number: _____ from: _____ to: _____

Did you report the incident to the airline? (circle one) Yes --- No

Did the incident impact the flight schedule/route? (circle any that apply)
delay --- diversion --- emergency landing --- don't know --- other: _____

Are you aware of any other documentation about conditions on this flight? (circle any that apply)
pilot log book – maintenance records – media report – passenger complaints – other: _____

During what phase of flight did you notice the event? (circle as many as apply)
gate --- taxi --- takeoff --- ascent --- cruise --- descent – landing --- taxi

Did you notice an odor? (circle one) Yes --- No
If yes, describe: _____

Did you notice a smoke/fume/haze? (circle one) Yes --- No
If yes, describe: _____

Did you have symptoms in-flight? (circle one) Yes --- No
If yes, describe: _____

5) What is the name of the hospital/lab that drew your blood? _____

6) How many hours between the time of your exposure and your blood draw? _____

7) Did you seek medical attention after the flight? (circle one) Yes --- No
If yes, describe: _____

8) Did you have symptoms the day after the flight? (circle one) Yes --- No
If yes, describe: _____



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9) Did you have symptoms beyond the day after the flight? (circle one) Yes --- No

If yes, describe, and indicate if you sought medical attention _____

10a) Did you have neurological symptoms prior to this exposure? (circle one) Yes – No

If yes, describe _____

10b) Have you been treated for neurological symptoms prior to this exposure? Yes -- No

If yes, describe _____

11) Diet and medications can influence how your body processes certain chemicals.

(a) Please list any medications/dietary supplements that you take

(b) Please list the foods/drinks you consumed during the 24 hours before the exposure (as best you can):

12) Any other comments:

Please fill out both pages and return with the basic questionnaire and your signed consent form to:

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Questions?
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