

Lung Injury Associated with Vaping – Patient Survey

Background Information

Any information you provide on this form may help us identify what is making people sick. If you would like help filling out this form, please ask a staff member. Thank you!

Name _____ Date of birth ___ / ___ / ___
 Race: White Black Other _____ Ethnicity: Hispanic Non-Hispanic

In the past 3 months, have you smoked any cigarettes (not in an e-cig?) Yes No

In the past 3 months, have you smoked any marijuana (eg. joints/bong)? Yes No

In the past 3 months, have you...

... vaped/Juuled any products that contain nicotine? Yes No

... vaped/dabbed any products that contain THC? Yes No

... used any Dank Vapes products? Yes No

Did you share any vaping products with someone who also got sick? Yes No

Are you part of the Illinois Medical Marijuana program? Yes No

When did you first start vaping or dabbing THC products? _____

Are you aware of the current outbreak of lung illness related to vaping? Yes No

If yes, did you change how you use e-cigarettes/vaping devices? Yes No

If yes, how? _____

Vaping Product Information

Please tell us about each product you have vaped/Juuled/dabbed in the past 3 months:

	Please provide details about each product	In what form did you use this product?	How many times a day did you use this product?	Where did you usually get this product?	What kind of device did you usually use with this product?
Product 1	Contains THC <input type="checkbox"/> CBD <input type="checkbox"/> Nicotine <input type="checkbox"/> Other <input type="checkbox"/> (Specify _____) Brand name: _____ Date first used: _____ Date last used: _____	<input type="checkbox"/> Pre-filled cartridge/pod <input type="checkbox"/> Liquid/oil not in pre-filled cart <input type="checkbox"/> Solid/wax <input type="checkbox"/> Leaf/flower <input type="checkbox"/> Other _____ Can public health get this product for testing? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> <1 x per day <input type="checkbox"/> 1-2 x per day <input type="checkbox"/> 3-5 x per day <input type="checkbox"/> >5 x per day <input type="checkbox"/> Not sure ↓ If >5x per day, how many times per day? ____	<input type="checkbox"/> Friend <input type="checkbox"/> Street <input type="checkbox"/> Gas station <input type="checkbox"/> Vape shop <input type="checkbox"/> Dealer <input type="checkbox"/> School <input type="checkbox"/> Medical dispensary (IL) <input type="checkbox"/> Dispensary (other state) <input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Disposable e-cig <input type="checkbox"/> E-cig for prefilled carts/pods <input type="checkbox"/> E-cig with a tank that you refill with liquid <input type="checkbox"/> Dab rig / Dab pen <input type="checkbox"/> Vaporizer (for dry herbs etc) <input type="checkbox"/> Mod device (e.g. with modifiable settings/voltage) <input type="checkbox"/> Other (please specify)
Product 2	Contains THC <input type="checkbox"/> CBD <input type="checkbox"/> Nicotine <input type="checkbox"/> Other <input type="checkbox"/> (Specify _____) Brand name: _____ Date first used: _____ Date last used: _____	<input type="checkbox"/> Pre-filled cartridge/pod <input type="checkbox"/> Liquid/oil not in pre-filled cart <input type="checkbox"/> Solid/wax <input type="checkbox"/> Leaf/flower <input type="checkbox"/> Other _____ Can public health get this product for testing? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> <1 x per day <input type="checkbox"/> 1-2 x per day <input type="checkbox"/> 3-5 x per day <input type="checkbox"/> >5 x per day <input type="checkbox"/> Not sure ↓ If >5x per day, how many times per day? ____	<input type="checkbox"/> Friend <input type="checkbox"/> Street <input type="checkbox"/> Gas station <input type="checkbox"/> Vape shop <input type="checkbox"/> Dealer <input type="checkbox"/> School <input type="checkbox"/> Medical dispensary (IL) <input type="checkbox"/> Dispensary (other state) <input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Disposable e-cig <input type="checkbox"/> E-cig for prefilled carts/pods <input type="checkbox"/> E-cig with a tank that you refill with liquid <input type="checkbox"/> Dab rig / Dab pen <input type="checkbox"/> Vaporizer (for dry herbs etc) <input type="checkbox"/> Mod device (e.g. with modifiable settings/voltage) <input type="checkbox"/> Other (please specify)

If you used more than two products, please list them on the next page

Additional Information

Can the Illinois Department of Public Health contact you for more information? Yes No

Can the FDA contact you for more information? Yes No

Contact information: **Phone number:** _____ **Email address:** _____

When you have completed this survey, please give it back to your healthcare provider.



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Additional Products (if you used more than two products)

	Please provide some details about each product	In what form did you use this product?	How many times a day did you use this product?	Where did you usually get this product?	What kind of device did you usually use with this product?
Product 3	Contains THC <input type="checkbox"/> CBD <input type="checkbox"/> Nicotine <input type="checkbox"/> Other <input type="checkbox"/> (Specify _____) Brand name: _____ Date first used: _____ Date last used: _____	<input type="checkbox"/> Pre-filled cartridge/pod <input type="checkbox"/> Liquid/oil not in pre-filled cart <input type="checkbox"/> Solid/wax <input type="checkbox"/> Leaf/flower <input type="checkbox"/> Other _____ Can public health get this for testing? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> <1 x per day <input type="checkbox"/> 1-2 x per day <input type="checkbox"/> 3-5 x per day <input type="checkbox"/> >5 x per day <input type="checkbox"/> Not sure If >5x per day, how many times per day? _____	<input type="checkbox"/> Friend <input type="checkbox"/> Street <input type="checkbox"/> Gas station <input type="checkbox"/> Vape shop <input type="checkbox"/> Dealer <input type="checkbox"/> School <input type="checkbox"/> Medical dispensary (IL) <input type="checkbox"/> Dispensary (other state) <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Disposable e-cig <input type="checkbox"/> E-cig for prefilled carts/pods <input type="checkbox"/> E-cig with a tank that you refill with liquid <input type="checkbox"/> Dab rig / Dab pen <input type="checkbox"/> Vaporizer (for dry herbs etc) <input type="checkbox"/> Mod device (e.g. with modifiable settings/voltage) <input type="checkbox"/> Other (please specify) _____
Product 4	Contains THC <input type="checkbox"/> CBD <input type="checkbox"/> Nicotine <input type="checkbox"/> Other <input type="checkbox"/> (Specify _____) Brand name: _____ Date first used: _____ Date last used: _____	<input type="checkbox"/> Pre-filled cartridge/pod <input type="checkbox"/> Liquid/oil not in pre-filled cart <input type="checkbox"/> Solid/wax <input type="checkbox"/> Leaf/flower <input type="checkbox"/> Other _____ Can public health get this for testing? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> <1 x per day <input type="checkbox"/> 1-2 x per day <input type="checkbox"/> 3-5 x per day <input type="checkbox"/> >5 x per day <input type="checkbox"/> Not sure If >5x per day, how many times per day? _____	<input type="checkbox"/> Friend <input type="checkbox"/> Street <input type="checkbox"/> Gas station <input type="checkbox"/> Vape shop <input type="checkbox"/> Dealer <input type="checkbox"/> School <input type="checkbox"/> Medical dispensary (IL) <input type="checkbox"/> Dispensary (other state) <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Disposable e-cig <input type="checkbox"/> E-cig for prefilled carts/pods <input type="checkbox"/> E-cig with a tank that you refill with liquid <input type="checkbox"/> Dab rig / Dab pen <input type="checkbox"/> Vaporizer (for dry herbs etc) <input type="checkbox"/> Mod device (e.g. with modifiable settings/voltage) <input type="checkbox"/> Other (please specify) _____
Product 5	Contains THC <input type="checkbox"/> CBD <input type="checkbox"/> Nicotine <input type="checkbox"/> Other <input type="checkbox"/> (Specify _____) Brand name: _____ Date first used: _____ Date last used: _____	<input type="checkbox"/> Pre-filled cartridge/pod <input type="checkbox"/> Liquid/oil not in pre-filled cart <input type="checkbox"/> Solid/wax <input type="checkbox"/> Leaf/flower <input type="checkbox"/> Other _____ Can public health get this for testing? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> <1 x per day <input type="checkbox"/> 1-2 x per day <input type="checkbox"/> 3-5 x per day <input type="checkbox"/> >5 x per day <input type="checkbox"/> Not sure If >5x per day, how many times per day? _____	<input type="checkbox"/> Friend <input type="checkbox"/> Street <input type="checkbox"/> Gas station <input type="checkbox"/> Vape shop <input type="checkbox"/> Dealer <input type="checkbox"/> School <input type="checkbox"/> Medical dispensary (IL) <input type="checkbox"/> Dispensary (other state) <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Disposable e-cig <input type="checkbox"/> E-cig for prefilled carts/pods <input type="checkbox"/> E-cig with a tank that you refill with liquid <input type="checkbox"/> Dab rig / Dab pen <input type="checkbox"/> Vaporizer (for dry herbs etc) <input type="checkbox"/> Mod device (e.g. with modifiable settings/voltage) <input type="checkbox"/> Other (please specify) _____
Product 6	Contains THC <input type="checkbox"/> CBD <input type="checkbox"/> Nicotine <input type="checkbox"/> Other <input type="checkbox"/> (Specify _____) Brand name: _____ Date first used: _____ Date last used: _____	<input type="checkbox"/> Pre-filled cartridge/pod <input type="checkbox"/> Liquid/oil not in pre-filled cart <input type="checkbox"/> Solid/wax <input type="checkbox"/> Leaf/flower <input type="checkbox"/> Other _____ Can public health get this for testing? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> <1 x per day <input type="checkbox"/> 1-2 x per day <input type="checkbox"/> 3-5 x per day <input type="checkbox"/> >5 x per day <input type="checkbox"/> Not sure If >5x per day, how many times per day? _____	<input type="checkbox"/> Friend <input type="checkbox"/> Street <input type="checkbox"/> Gas station <input type="checkbox"/> Vape shop <input type="checkbox"/> Dealer <input type="checkbox"/> School <input type="checkbox"/> Medical dispensary (IL) <input type="checkbox"/> Dispensary (other state) <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Disposable e-cig <input type="checkbox"/> E-cig for prefilled carts/pods <input type="checkbox"/> E-cig with a tank that you refill with liquid <input type="checkbox"/> Dab rig / Dab pen <input type="checkbox"/> Vaporizer (for dry herbs etc) <input type="checkbox"/> Mod device (e.g. with modifiable settings/voltage) <input type="checkbox"/> Other (please specify) _____
Product 7	Contains THC <input type="checkbox"/> CBD <input type="checkbox"/> Nicotine <input type="checkbox"/> Other <input type="checkbox"/> (Specify _____) Brand name: _____ Date first used: _____ Date last used: _____	<input type="checkbox"/> Pre-filled cartridge/pod <input type="checkbox"/> Liquid/oil not in pre-filled cart <input type="checkbox"/> Solid/wax <input type="checkbox"/> Leaf/flower <input type="checkbox"/> Other _____ Can public health get this for testing? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> <1 x per day <input type="checkbox"/> 1-2 x per day <input type="checkbox"/> 3-5 x per day <input type="checkbox"/> >5 x per day <input type="checkbox"/> Not sure If >5x per day, how many times per day? _____	<input type="checkbox"/> Friend <input type="checkbox"/> Street <input type="checkbox"/> Gas station <input type="checkbox"/> Vape shop <input type="checkbox"/> Dealer <input type="checkbox"/> School <input type="checkbox"/> Medical dispensary (IL) <input type="checkbox"/> Dispensary (other state) <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Disposable e-cig <input type="checkbox"/> E-cig for prefilled carts/pods <input type="checkbox"/> E-cig with a tank that you refill with liquid <input type="checkbox"/> Dab rig / Dab pen <input type="checkbox"/> Vaporizer (for dry herbs etc) <input type="checkbox"/> Mod device (e.g. with modifiable settings/voltage) <input type="checkbox"/> Other (please specify) _____

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