Boston University Medical Center

School of Medicine
80 East Concord Street
Boston, Massachusetts 02118

Department of Neurology
Office of the Chairman
(617) 247-5136

December 13, 1982

Stanley Sulkes
5822 Wyatt Avenue
Cincinnati, Ohio 45213

Dear Mr. Sulkes:

As Chairman of the Department of Neurology at Boston University School of Medicine, I am interested in studying the effects that various substances have on the nervous system. Last month, I met with Dr. Robert Kehoe in order to discuss the research he conducted at the Kettering Laboratory in the area of the metabolism of lead as well as raise the question of the possible long-term effects from that exposure. He gave me permission to contact you and the other participants in that study where lead was ingested in the form of an aqueous solution of lead salt or inhaled in the form of airborne particulates. I am interested in learning of your current health status and have enclosed a questionnaire for that purpose.

Dr. Kehoe was able to give me the names of all the participants in that study but was uncertain of six individuals' current addresses. They are as follows: Floyd Creech, Steven Balog, Martin Riehle, Ivan Ferneau, Harvey Reed, and Donald Hayes. Should you know of their whereabouts, I would be most grateful if you could send me that information when you return the enclosed questionnaire.

I am most grateful for your cooperation in filling out the enclosed form and returning it to me at your earliest convenience. I will keep you informed of the results of this survey. Thank you for your assistance.

Sincerely yours,

Robert G. Feldman, M.D.
Professor and Chairman
Department of Neurology

RGF/cg

cc: Robert A. Kehoe, M.D.

QUESTIONNAIRE TO PARTICIPANTS OF KEHOE STUDY AT KETTERING LABORATORY

Today's Date: ___ - / ___ / ___

Background Information

2. Name: _____
3. Address: _____
4. Telephone #: _____
5. Soc. Sec. #: _____
6. Date of Birth: ___ / ___ / ___
7. Place of Birth: _____
8. Sex: _____
9. Race: _____
10. Marital Status: _____
11. Height: _____
12. Weight: _____
13. Education (highest level completed): _____
14. Did you participate in the Kehoe study at the Kettering Laboratory? ___Yes ___No

    If yes, what were the dates of that participation:

    Dates

    From _____ To _____

    _____ _____

    _____ _____

15. Please explain your participation in the study (how you were exposed to lead, how much lead, etc): _____

    _____

    _____

    _____

16. Did you experience or have you experienced any of the following symptoms?

Symptoms	During your participation in the study	Since your participation in the study	Please describe (actual symptoms and when symptoms started):
Numbness and tingling in the arms or legs	___Yes ___No	___Yes ___No	_____
Muscle weakness in the arms or hands	___Yes ___No	___Yes ___No	_____
Muscle twitching in the muscles of the arms or legs	___Yes ___No	___Yes ___No	_____
Decrease in size of muscles in the arms or hands (muscle wasting)	___Yes ___No	___Yes ___No	_____

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	(During particip.)		(Since particip.)		
Numbness and tingling in the legs or feet	___Yes	___No	___Yes	___No	_____
Muscle weakness in the legs or feet	___Yes	___No	___Yes	___No	_____
Muscle twitching in the muscles of the legs or feet	___Yes	___No	___Yes	___No	_____
Decrease in size of muscles in legs or feet (muscle wasting)	___Yes	___No	___Yes	___No	_____
Change in pitch or quality of voice	___Yes	___No	___Yes	___No	_____
Difficulty chewing or swallowing	___Yes	___No	___Yes	___No	_____
Difficulty speaking	___Yes	___No	___Yes	___No	_____
Change in the way you walk	___Yes	___No	___Yes	___No	_____
Tremors	___Yes	___No	___Yes	___No	_____
Frequent mood changes	___Yes	___No	___Yes	___No	_____
Memory problems	___Yes	___No	___Yes	___No	_____
Frequent muscle cramps	___Yes	___No	___Yes	___No	_____
Muscle paralysis	___Yes	___No	___Yes	___No	_____

Medical/Family History

17. Have you or anyone in your family been diagnosed as having any of the following:

			Please describe (who, when diagnosed, associated symptoms, etc):
Diabetes	___Yes	___No	_____
Cancer	___Yes	___No	_____
Seizures	___Yes	___No	_____
Headaches	___Yes	___No	_____
Thyroid trouble	___Yes	___No	_____
Stroke	___Yes	___No	_____
Brain tumor	___Yes	___No	_____
Senility	___Yes	___No	_____
Kidney trouble	___Yes	___No	_____
Allergies	___Yes	___No	_____
Bone fracture (state location of injury)	___Yes	___No	_____
Chronic bronchitis	___Yes	___No	_____
Stomach problems	___Yes	___No	_____
Arthritis	___Yes	___No	_____
Anemia	___Yes	___No	_____
Gout	___Yes	___No	_____
Frostbite (state body part of injury)	___Yes	___No	_____
Heart disease	___Yes	___No	_____
Back problems	___Yes	___No	_____
High blood pressure	___Yes	___No	_____
Multiple sclerosis	___Yes	___No	_____
Parkinson's disease	___Yes	___No	_____

Cerebral palsy	___Yes	___No	_____
Muscular dystrophy	___Yes	___No	_____
Tremors	___Yes	___No	_____
Polio	___Yes	___No	_____
Motor neuron disease	___Yes	___No	_____
Amyotrophic lateral sclerosis (ALS)	___Yes	___No	_____
Huntington's disease	___Yes	___No	_____
Vitamin B12 deficiency	___Yes	___No	_____
Other	___Yes	___No	_____

18. Have you ever had surgery? ___Yes ___No

If yes, please state reason for surgery and dates: _____

_____

_____

_____

19. What is your average intake of alcohol (1 shot of liquor, 1 glass of wine or 1 bottle of beer = 1 drink)?

Fill in most appropriate blank:

_____ # drinks/ _____day, _____week, _____month

Occupational/Exposure History

19. Have you been exposed to any of the following at work or while involved in hobbies? (For example, exposure would mean having had skin contact with or ingestion of various substances or having inhaled fumes or dust.)

Substance			Please describe (dates, nature of exposure, etc.):
Lead	___Yes	___No	_____
Mercury	___Yes	___No	_____
Arsenic	___Yes	___No	_____
Aluminum	___Yes	___No	_____
Manganese	___Yes	___No	_____
Acrylamide	___Yes	___No	_____
Hexane	___Yes	___No	_____
Trichloroethylene (Trichlor, Trilene)	___Yes	___No	_____
Perchloroethylene (Perchlor, Perc)	___Yes	___No	_____
Methyl n-butyl ketone (MBK)	___Yes	___No	_____
Carbon disulfide	___Yes	___No	_____
Toluene	___Yes	___No	_____
Methylene chloride	___Yes	___No	_____
Carbon monoxide	___Yes	___No	_____
Insecticides	___Yes	___No	_____
Metal dust	___Yes	___No	_____
Solvents	___Yes	___No	_____
Glues	___Yes	___No	_____

Other substances (that you may work with or have worked with in your job or while doing hobbies): _____

_____

_____

20. Are you currently working? ___Yes ___No Occupation: _____

21. Place of employment: _____

22. Month and year job began: ____/____/____

23. Briefly describe your job tasks (how you perform your job; the substances you work with, etc.): _____

_____

_____

24. If not currently working, please state reason: _____

_____

25. Month and year job ended: ____/____

26. Please list your previous jobs starting with the most recent one:

JOB	DATES FROM:	TO:	JOB TASKS	SUBSTANCES YOU WORKED WITH

Thank you for taking the time to complete this questionnaire. Please feel free to give a copy of this form to your personal physician, should he/she wish to contact us.

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