Thank you for completing this voluntary questionnaire. *We appreciate any information that you can provide. As a part of the U.S. government's efforts to investigate health incidents reported by U.S. personnel in Cuba, we intend to share your information only with those involved in this investigation and only in accordance with applicable U.S. laws and policies, including the Privacy Act of 1974. (Please see the Privacy Act Statement below for more information.) If there are any further questions for you, the Department will contact you directly. Please continue to consult with your medical professional as needed, and refer to our Cuba Travel Advisory and other travel information at travel.state.gov. Thank you.*

Privacy Act Statement

Authority: The Department of State requests this information under the authority of 22 U.S.C. § 3904 and 22 U.S.C. § 4802.

Purpose: The principal purpose of collecting this information is to assist in protecting the security of the United States and the safety and security of its employees and private citizens abroad.

Routine Uses: The information solicited on this form may be made available to federal, state, local, or foreign law enforcement agencies, and other U.S. government or foreign agencies with statutory or other lawful authority to maintain the information, in coordination with the Department of State and in accordance with the Privacy Act. More information on routine uses applicable to completed questionnaires can be found in the System of Records Notice State-05, Overseas Citizen Services and Other Overseas Records. In some circumstances, completed questionnaires may also be maintained by the Bureau of Diplomatic Security in accordance with the System of Records Notice State-36, Security Records.

Disclosure: Responses are voluntary.

Personal Details

1. Date survey completed:
2. Full name:
3. Date and place of birth:
4. Gender:
5. Phone number:
6. Email address:
7. Permanent address:
8. Employer:
9. Have you ever worked for the U.S. government or served in the U.S. military? If so, in what capacity?

Trip Details

1. What date did you arrive in the location(s) where you experienced symptoms?

2. What date did you depart the location(s) where you experienced symptoms?
3. What was your purpose in visiting the location(s) where you experienced symptoms?
4. What areas and locations did you visit?
5. What type of activities did you engage in?
6. What other countries did you visit prior to the location(s) where you experienced symptoms (and when)?
7. What other countries did you visit after the location(s) where you experienced symptoms (and when)?

Incident

1. What was the location and address of the incident?

2. What was the date and time of the incident?

3. How long did the incident last?

4. How long did the health effects of the incident, if any, last?

5. Was the incident reported to local authorities? If so, what was the time and date, and what was their response?

6. Is there a recording of the incident?

7. What were you doing when you first noticed the incident?

8. Did the incident appear to originate from a specific location? If so, where? Did it change in any way?

9. Did you remain in the location or leave, and if you left, how did the incident's effects change?

10. Please list any electronic devices present during the phenomenon (WiFi routers, TVs, iPads, computers, microwaves, air conditioning units, etc.) and their position in relation to you. Did these devices do anything unusual before/during/after the incident?

11. Did you notice anything unusual before or after the incident? (People, vehicles or other unusual concerns, changes in the environment?)

12. Were there other people in the area at the time of the incident? If so, did they have any ill effects? Were any pets or other animals present at the time of the incident? How did these animals respond?

13. Did you ever experience health effects similar to those from the incident at any other time? If so, when, and was it identical or different?

14. Were you located in a public space at the time of the incident? (If in a hotel, were windows nearby and/or were you close to the street?)

Description of sounds (if applicable):

1. How long was the duration of the sound?

2. Describe the nature of the sound in your own words. Can you equate the noise to a sound with which you are familiar?

3. Was the sound continuous or intermittent?

4. How did the sound affect you or make you feel? What part of your body was affected?

Medical History

1. In general, how would you rate your health today on a scale of (1) very good to (5) very poor?

2. Do you have any chronic medical conditions? If yes, list them here.

3. Have you ever suffered a head injury, to include concussions, blast, or other injuries in the past? If yes, list the details including dates.

Immediate Symptoms

This section of the form asks about any symptoms that you may have had immediately after the incident:

1. Headache Choose an item.
2. Head pressure Choose an item.
3. Reduced hearing sensitivity Choose an item.
4. Ear pain or pressure Choose an item.
5. Ringing in the ears Choose an item.
6. Nausea or vomiting Choose an item.
7. Dizziness or vertigo Choose an item.
8. Blurred vision Choose an item.
9. Balance problems Choose an item.
10. Sensitivity to light Choose an item.
11. Sensitivity to noise Choose an item.
12. Feeling slowed down Choose an item.
13. Feeling like “in a fog” Choose an item.
14. “Don’t feel right” Choose an item.
15. Difficultly concentrating Choose an item.
16. Difficulty remembering Choose an item.
17. Fatigue or low energy Choose an item.

18. Confusion Choose an item.
19. Drowsiness Choose an item.
20. Trouble with sleep Choose an item.
21. More emotional Choose an item.
22. Irritability Choose an item.
23. Sadness Choose an item.
24. Anxiety or nervousness Choose an item.
25. And other symptoms after travel to the location(s) where you experienced symptoms? If yes describe it in the comment box
    Click here to enter text.

Current or Recent Symptoms

This section of the form asks about <u>symptoms that you currently have or have had in the last 30 days</u>:

1. Headache Choose an item.
2. Head pressure Choose an item.
3. Reduced hearing sensitivity Choose an item.
4. Ear pain or pressure Choose an item.
5. Ringing in the ears Choose an item.
6. Nausea or vomiting Choose an item.
7. Dizziness or vertigo Choose an item.
8. Blurred vision Choose an item.
9. Balance problems Choose an item.
10. Sensitivity to light Choose an item.
11. Sensitivity to noise Choose an item.
12. Feeling slowed down Choose an item.
13. Feeling like "in a fog" Choose an item.
14. "Don't feel right" Choose an item.
15. Difficultly concentrating Choose an item.
16. Difficulty remembering Choose an item.
17. Fatigue or low energy Choose an item.
18. Confusion Choose an item.
19. Drowsiness Choose an item.
20. Trouble with sleep Choose an item.
21. More emotional Choose an item.
22. Irritability Choose an item.
23. Sadness Choose an item.
24. Anxiety or nervousness Choose an item.
25. And other symptoms after travel to the location(s) where you experienced symptoms? If yes describe it in the comment box
    Click here to enter text.

Additional Information

1. If there is anything else you would like to mention about your health, include it here.

2. Have you sought medical attention for the aforementioned symptoms and if so, what were the results?
   Click here to enter text.
3. Did anyone traveling with you have a similar experience?

4. Do you have any other comments?
   Click here to enter text.

5. Do you have any other comments about unusual sounds or other events noticed in the location(s) where you experienced symptoms?

Thank you for completing this survey.