



Environmental Toxic Exposure

Name: _____

Date: _____

This form is completely confidential. The information contained herein cannot be given to anyone outside this office without your written permission. Thank you for answering all questions completely. **Please explain any “yes” answers in the space provided with the question.**

	Yes (Y)	No (N)
Symptoms of reduced chemical metabolism		
1. Have you often had to lower the regular dose of prescription, over-the-counter medication or herbal supplements because you were too sensitive to normal doses?	Y	N
2. Do you avoid caffeine in the afternoon or all together because it can keep you up at night?	Y	N
3. Have you ever experienced adverse reactions to medications? If so, what happened?	Y	N
4. Do you smell odors when others can't? What kinds of odors?	Y	N
5. Do you have a sudden onset of symptoms (headaches, skin rashes, nausea, fatigue, shortness of breath, etc.) on exposure to chemicals, mold, dust, pollens, or other environmental allergens? What symptoms?	Y	N
6. Please list all the chemicals that you get adverse reactions to:		
Historical Exposures		
7. When do you last remember feeling really great?		
8. Describe your residence when your illness began (type, age, carpets, heat source, paint, proximity to industry, etc.)		
9. Describe your work environment when your illness began (type of building, ventilation, toxic exposure, neighboring businesses, etc.)		

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	Yes (Y)	No (N)
10. Have you ever had to change your residence or job due to health reasons?	Y	N
11. Have you ever had a known chemical injury or major exposure?	Y	N
12. Have you ever been exposed to chemicals or toxic metals in the course of work or schooling? When? How long? Name them.	Y	N
13. Have you ever worked where adjacent businesses regularly used chemicals or toxic metals? When? How long? Name them.	Y	N
14. Have you ever worked in a building where the windows were always closed? When? How long?	Y	N
15. Have you ever worked where you or your co-workers complained about the air quality or smells in the workplace, or were injured in any way? When? How long?	Y	N
16. Have you ever heard about any Air Quality Incidents in your place of work? When? Describe what you heard.	Y	N
Residence		
17. Have you ever lived near any heavy industries that regularly emitted waste into the air or water (i.e., golf course, dry cleaner, plant, shipyard, mine, chemical factory, dumpsite, or landfill)? What type of pollution? When? How long?	Y	N
18. Have you ever lived in a house built before 1978? How long were you there?	Y	N
19. Have you ever lived on or adjacent to an agricultural area? What kind of area was it? When? How long?	Y	N
20. Have you ever lived in a home where mold was a problem? When? How long?	Y	N

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	Yes (Y)	No (N)
21. Have you ever lived in a home with a water leak or water damage? When? How long?	Y	N
22. Have you ever lived in a mobile home? When? How long?	Y	N
23. Have you ever lived in a home where turning on the central air or heat caused you or family members to feel sick? When? How long?	Y	N
24. Have you ever felt there were conditions in your home that affected your health (use of aerosol sprays, chemicals, cleansers, construction, painting, etc.)? When? How long?	Y	N
25. Are pesticides or herbicides used inside or outside your home?	Y	N
26. Have you ever lived near a busy highway, street or gas station? When? How long?	Y	N
27. When were your air ducts last cleaned?		
28. When were your air filters last changed? _____ How frequently are they changed? _____		
29. Is your stove gas or electric? _____ Is your furnace gas or electric? _____ Water heater gas or electric? _____		
30. Do you wear dry cleaned clothing? If yes how frequently and in which room are they stored?	Y	N
31. Are there animals in your home?	Y	N
32. Do you have air purifiers or water filters in your home? If so, what kind?	Y	N
33. Do you heat food in a microwave?	Y	N
34. Do you have candles in your home?	Y	N

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	Yes (Y)	No (N)
Lifestyle		
(Note: To answer when, write in the start & stop dates of use – i.e., 02/95 – now, or ‘99-’01)		
35. Do you regularly get hair coloring, permanents or visit a beauty salon?	Y	N
36. Have you ever had acrylic fingernails or been in a beauty shop where acrylic nails are done? If so, when?	Y	N
37. Have you ever used scented soaps, detergents, potpourri, perfumes, etc.? Do you still?	Y	N
38. Have you ever used fabric softener? Do you still?	Y	N
39. Have you ever used recreational drugs? If so, when and what compounds?	Y	N
40. Have you ever lived with animals that received treatment for fleas or ticks? If so, when?	Y	N
41. Have you ever lived in a home with new carpet, new furniture, and new construction? If so, when?	Y	N
42. Have you ever lived on or near a golf course or other area where heavy pesticides and herbicides are used regularly? If so, when?	Y	N
43. Have you ever regularly worked with chemicals in any hobby (i.e., solvents, paints, stains, cleaners, etc.)? If so, when?	Y	N
44. Have you ever had silver fillings put in your teeth? If so, when?	Y	N
45. Do you still have silver fillings in your mouth? If yes, how many and how long have they been in your mouth?	Y	N
46. Have you ever had root canals, implants, or bridgework done on your teeth? If so, when?	Y	N

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	Yes (Y)	No (N)
47. Have you ever had any implants (stainless steel, Teflon, silicone, etc.) put into your body? If so, when and what kind of implants?	Y	N
48. Have you ever been given vaccinations? If so, when? (If you received all childhood vaccinations, write "all".)	Y	N
49. Have you ever had reactions to any vaccinations? If so, what and when?	Y	N
50. Have you ever smoked? If so, for how long?	Y	N
51. Have you ever lived with others that smoked? If so, for how long and how old were you?	Y	N
52. How often do you eat fish? (What types of fish do you eat?)	Y	N

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Residence History

Fill in the table below listing all residences in which you have lived. Start with the present and go back as far as you can remember. Ask family members and parents, if alive, for additional information. In the Known Exposures column write the words in bold from the descriptions below when they apply.

Residence Location (City, county, state, zip code)	Dates From - To (mo. & yr.)	City, Suburb, Rural	Amount of Traffic (hi-med -lo)	Age of Home at the Time	Known Exposures (choose from the list below)	Did you have to move out for health reasons? If so, why?

- **Lead** pipes or paint
- Commercial business nearby – write in the **type of industry or business name**
- Frequent use of **mothballs**
- **Dry cleaned** clothes kept in bedroom closet
- **Pets** sprayed, dipped or collared for bugs
- Use of **air fresheners** (specify by brand)
- Regular use of **chemicals** (i.e., paints, cleaners; think of hobbies in each location)
- **Asbestos**
- Unfinished **pressure treated lumber** (outdoor play sets, decking, patio furniture)
- **Pesticide/herbicide** use – yours or your neighbors - lawns, house bugs, gardens
- Family members bringing home contaminants on **clothes**
- Major **power lines** over or near the home
- **Attached garage**
- Storage of **gasoline, solvents, etc., in garage**
- **Oil tank in garage**
- Tobacco **smoke** (you or someone in house smoked)
- **New construction, remodeling**
- **Mobile Home**
- **New furniture, and/or carpets**
- **Waterbed**
- **Mold**
- **Gas or oil heat**
- **Gas stove, woodstove, fireplace**
- **Furnace ducts or filter**, not cleaned at least yearly

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Occupational History

Fill in the table below listing all jobs at which you have worked, including short-term, seasonal, and part-time employment. Start with your present job and go back to the first. Use additional paper if necessary.

Workplace (name, city, county, state, zip code)	Dates worked From - To (mo. & yr.)	Full- time Yes/No	Type of Industry (Describe)	Describe your job duties	Known health hazards in workplace (i.e., dusts/ solvents)	Protective equipment used	Were you ever off work for a health problem or injury?