



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 include your name and date on each page of this form. **Please explain any "yes" answers in the space provided with the question.**

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?	Yes	No
2. Do you avoid caffeine in the afternoon or all together because it can keep you up at night?	Yes	No
3. Have you ever experienced adverse reactions to medications? If so, what happened?	Yes	No
4. Do you smell odors when others can't? What kinds of odors?	Yes	No
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?	Yes	No
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.)		
10. Have you ever had to change your residence or job due to health reasons?	Yes	No
11. Have you ever had a known chemical injury or major exposure?	Yes	No



Workplace Exposures

12. Have you ever been exposed to chemicals or toxic metals in the course of work or schooling? When? How long? Name them.	Yes	No
13. Have you ever worked where adjacent businesses regularly used chemicals or toxic metals? When? How long? Name them.	Yes	No
14. Have you ever worked in a building where the windows were always closed? When? How long?	Yes	No
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?	Yes	No
16. Have you ever heard about any Air Quality Incidents in your place of work? When? Describe what you heard.	Yes	No

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?	Yes	No
18. Have you ever lived in a house built before 1978? How long were you there?	Yes	No
19. Have you ever lived on or adjacent to an agricultural area? What kind of area was it? When? How long?	Yes	No
20. Have you ever lived in a home where mold was a problem? When? How long?	Yes	No
21. Have you ever lived in a home with a water leak or water damage? When? How long?	Yes	No
22. Have you ever lived in a mobile home? When? How long?	Yes	No
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?	Yes	No



ENVIRONMENTAL TOXIC EXPOSURE

Name: _____ Date: _____

Residence (cont.)

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?	Yes	No
25. Are pesticides or herbicides used inside or outside your home?	Yes	No
26. Have you ever lived near a busy highway, street or gas station? When? How long?	Yes	No
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? electric?	Is your furnace gas or electric?	Water heater gas or
30. Do you wear dry cleaned clothing? If yes how frequently and in which room are they stored?	Yes	No
31. Are there animals in your home?	Yes	No
32. Do you have air purifiers or water filters in your home? If so, what kind?	Yes	No
33. Do you heat food in a microwave?	Yes	No
34. Do you have candles in your home?	Yes	No

Lifestyle (Note: To answer when, write in the start and stop dates of use – i.e., 2/95-now, or '99-'01)

35. Do you regularly get hair coloring, permanents or visit a beauty salon?	Yes	No
36. Have you ever had acrylic fingernails or been in a beauty shop where acrylic nails are done? If so, when?	Yes	No
37. Have you ever used scented soaps, detergents, potpourri, perfumes, etc.? Do you still?	Yes	No
38. Have you ever used fabric softener? Do you still?	Yes	No



39. Have you ever used recreational drugs? If so, when and what compounds?	Yes	No
40. Have you ever lived with animals that received treatment for fleas or ticks? If so, when?	Yes	No
41. Have you ever lived in a home with new carpet, new furniture, and new construction? If so, when?	Yes	No
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?	Yes	No
Note: To answer when, write in the start and stop dates of use – i.e., 2/95-now, or '99-'01)		
43. Have you ever regularly worked with chemicals in any hobby (i.e., solvents, paints, stains, cleaners, etc.)? If so, when?	Yes	No
44. Have you ever had silver fillings put in your teeth? If so, when?	Yes	No
45. Do you still have silver fillings in your mouth? If yes, how many and how long have they been in your mouth?	Yes	No
46. Have you ever had root canals, implants, or bridgework done on your teeth? If so, when?	Yes	No
47. Have you ever had any implants (stainless steel, Teflon, silicone, etc.) put into your body? If so, when and what kind of implants?	Yes	No
48. Have you ever been given vaccinations? If so, when? (If you received all childhood vaccinations, write "all".)	Yes	No
49. Have you ever had reactions to any vaccinations? If so, what and when?	Yes	No
50. Have you ever smoked? If so, for how long?	Yes	No
51. Have you ever lived with others that smoked? If so, for how long and how old were you?	Yes	No
52. How often do you eat fish? (What types of fish do you eat?)		



ENVIRONMENTAL TOXIC EXPOSURE / RESIDENCE HISTORY

Name: _____ Date: _____

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)	Dates From - To (Mo. & yr.)	City, subur b, 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?
ZIP CODE						
ZIP CODE						
ZIP CODE						
ZIP CODE						
ZIP CODE						

- **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



ENVIRONMENTAL TOXIC EXPOSURE / OCCUPATIONAL HISTORY

Name: _____ Date: _____

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)	Dates worked From - To (mo. & yr.)	Full time Yes/N o	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?
ZIP CODE							
ZIP CODE							
ZIP CODE							
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