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Occupational and Environmental Health
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HEALTH AND ENVIRONMENTAL HISTORY

IF YOU CANNOT KEEP YOUR APPOINTMENT, you must notify the office at (301-241-4346) 48 hours before your appointment (earlier if possible) so that we can try to schedule another patient. If you do not notify us at least 24 hours in advance **you will be charged $100** for a missed appointment/visit.

Name: ____________________ **Date:** ____________
Address: ____________________ **Age:** ____________
____________________ **Date of Birth:** ____________

Home Phone: ____________ **Work Phone:** ____________ **Social Security #**____________

Does your current health significantly reduce your ability to do your job, housework, errands, chores, and/or other needed activities? No A little Moderately Severely

IF YES, describe: ____________________
____
____
____

Have you had a burning-like feeling in eyes, nose, throat, etc.: No Yes Not Sure
If yes, when first occurred? ____________________

DO NOT WRITE BELOW THIS LINE ON THIS PAGE -- PROCEED TO PAGE 2

DIAGNOSES: Toxic Encephalopathy **[** RADS Upper Lower **]** Asthma Migraines Chronic Fatigue Other:
____

CAUSAL EXPOSURE: HOME SCHOOL Rx WORK/GOV'T WORK/PRIVATE A **OTHER UNKNOWN**

If work, Employer: ____________________

SITUATION OF EXPOSURE: PESTICIDE CARPET/RENOVATION SICK BLDG. OTHER UNKNOWN

CHEMICALS INVOLVED: ____________________
____

CHEMICAL PRODUCT(S) INVOLVED: ____________________
____
____

REFERRING DOCTOR (NAME/ADDRESS/PHONE NUMBER): ____________________
____
____

MEDICAL

1. For each situation described below, answer the questions at the top of each column. By "sick", we mean anything that **YOU** consider to be either a major or a minor health problem. Put a check in the appropriate box.

	Would you be sick if you had to spend 4 hours…….?					**Would you be sick if you had to spend 20 minutes …….?**				
Exposures:	No	A Little	Moder-ately	A Lot	Don't Know	No	A Little	Moder -ately	A Lot	Don't Know
a.Next to person smoking cigarettes outside										
b.Driving in heavy traffic with windows open										
c.Around workers tarring a road										
For the next questions, assume you are inside with no open windows…										
d.In a room sprayed with pesticides 4 hrs ago										
e.In room painted 24 hrs ago with water-based paint										
f.Shopping in an enclosed mall										
g.In room with wall/wall carpet 1 wk old										
h.Sitting next to a person wearing perfume/ cologne										
i.Cooking on a stove using natural gas										
j.Being around/using carbonless copy paper										
k.Sitting next to someone with fabric softener on clothing										

Would you be sick if you had to …?	No	A Little	Moderately	A Lot	Don't Know
l. Drink one glass of city (chlorinated) water					
m. Try on newly dry cleaned clothing					
n. Walk down the detergent aisle at a grocery store					
o. Use self-serve at a gas station					
p. Use a bathroom with a scented air freshener					
q. Read a freshly printed newspaper					
r. Wear synthetic fabrics					
s. Being around or using carbonless copy paper					
t. Swim for 20 minutes in a chlorinated pool					
u. Wear clothing laundered in chlorine bleach					
v. Wear clothing laundered with perfumed laundry Products					
w. Use bleach in your toilet					

***Question 1. Was assembled from a longer questionnaire used for research by Johns Hopkins (A. Davidoff).**

2. Describe a typical reaction (if any), listing symptoms in order of onset, and describing the time frame. If your reactions are quite different from time to time, describe this also. Put **None** if no reactions.

____

____

____

____

3. Please describe your **AVERAGE** reaction, (if any) to a chemical exposure in a public place (fill in the correct number of minutes, hours, or days or check "no reaction" if you do not experience the problem):

a. How long does it take before you feel as well as you did before the exposure?

____Minutes ____Hours ____Days ____No reaction.

b. How long does it take before you can think as clearly as before it began?

____Minutes ____Hours ____Days ____No reaction

c. How long before you recover energy to do most of your usual activities?

____Minutes ____Hours ____Days ____No reaction ____ Don't recover

d. Describe typical symptoms you experience during such a reaction, if any, in the order they occur:

____

____

____

4. Do you feel that you have more health problems than you used to have when in certain places or around certain things?

No Yes Not Sure

IF YES,

a. When did you first notice this? ____(Specify month & year)

b. When do you remember last feeling really well, without any health problems around places or things?

___________________________ (Specify month & year)

5. We will use these questions to evaluate your response to treatment. These questions ask about symptoms you may have experienced commonly. **Circle appropriate number. Rate the severity of your symptoms on a 0 to 10 scale:**

0=not at all a problem 5=moderate symptoms 10=disabling symptoms.

a. Problems with your head, such as headaches, or a feeling Of pressure or fullness in your face or head?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
b. Problems with your ability to think, such as difficulty Concentrating or remembering things, feeling spacey, or Having trouble making decisions?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
c. Problems with your mood, such as feeling tense or nervous, Irritable depressed, having spells of crying or rage, or loss Of interest in things you used to enjoy?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
d. Problems with balance or coordination, with numbness or Tingling in your extremities, or with focusing your eyes?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
e. Problems with your muscles or joints such as pain, aching, cramping, stiffness or weakness?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
f. Problems with your skin such as a rash, hives or dry skin?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
g. Problems with your urinary tract or genitals, such as pelvic pain or frequent or urgent urination? (**For Women**: or discomfort or other problems with your menstrual periods?)	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
h. Problems with your stomach or digestive tract, such as abdominal pain or cramping, abdominal swelling or bloating, nausea, diarrhea, or constipation?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
i. Problems with your heart or chest, such as a fast or irregular heart rate, skipped beats, your heart pounding, Or chest discomfort?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
j. Problems with burning or irritation of your eyes or Problems with your airway or breathing, such as feeling Short of breath, coughing, or having a lot of mucus, Post nasal damage, or respiratory infections?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Research question from Dr. Claudia Miller

6. List below doctor's name(s) seen in the last 1-2 years, the year(s) of your visit(s), and the address(es), starting with doctor you saw first. (Use extra paper if needed).

DOCTOR'S NAME	ADDRESS/PHONE	YEAR(S)

7. Have you seen a doctor because of health problems with certain places or things?

No Yes

IF YES, ask your doctor(s) to provide you with a copy of your medical records and bring these medical records with you when you visit Dr. Ziem for the first time.

8. On a separate piece paper, please type (neatly print) a **narrative describing how/when your illness began.** Describe in time order from the beginning and list dates as often as possible. If one (or more) chemical exposures were involved, describe where you were in relation to it, how long you were exposed, what your symptoms were, and how soon after exposure those symptoms developed.

9. Do you have **pain** once a week or more? Yes No

a. **IF YES**, how often? Weekly 2-4 times/week Almost daily Other: ________

b. How severe is pain usually? Mild Moderate Severe

c. How long does it usually last? 1 hr or less 2-4 hours □ 5-8 hours □ Other: ___hours ____days.

d. Where is the pain? ____

____

____

10. Have you had pain for over 3 months (persisting or on and off) in:

a. Your shoulders, elbows, arms or wrists? No Yes

IF YES, is this: Right side only Left side only Both sides

b. Your hips, knees, legs or ankles? No Yes

IF YES, is this: Right side only Left side only Both sides

c. Along or near your back, neck or breast bone? No Yes

11. List all the medications that you are currently taking, the dose and how often you take them, what they are for, if they help, and what bothersome side effects you experience. If you have any doubt about your answers, bring the medication bottle(s) with you to your appointment. Include any shots or medications for allergies and vitamins.

Name of Medication	Dose/ Frequency	Purpose	Helps?	Side Effects:

12. Check appropriate box to describe your health/life as accurately as you can before & after your exposure/chronic illness.

	Never	Rarely	Sometimes	Often	Most of the time
a. Difficulty thinking clearly					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
b. Short attention span					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
c. Problem thinking quickly					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
d. Trouble understanding others					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
e. Get lost					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
f. Forget what someone tells me					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
g. Forget what happened after a few minutes					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
h. Trouble understanding what I read					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
i. Forget what I read					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
j. Sleep problems					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					

12. Continued	Never	Rarely	Sometimes	Often	Most of the
k. Easily tired					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
l. Muscle Twitching					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
m. Muscle Spasms					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
n. Seizures or Fits					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
o. Blurred Vision					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
p. Reduced Hearing					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
q. Poor Balance					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
r. Poor Sense of Smell					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
s. Numbness, Tingling or Arms and Legs					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
t. Joint Pains					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
u. Dropping Things					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
v. Tremor, Shaking					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					

**Question 11 was assembled from a longer questionnaire by Dr. Raymond Singer*

13. **For the symptoms and health problems listed below.** If you have had the problem in the last year, circle the number that best describes how often the symptom occurs.

Symptom	Daily to Almost Daily	Several Times/ Week	Once A Week	Several Times/ Month	Once/ Month or Less	Rarely If Ever	Not Sure
Headache	1	2	3	4	5	6	7
Numbness, Tingling	1	2	3	4	5	6	7
Weakness in a body part	1	2	3	4	5	6	7
Lightheadedness, dizziness	1	2	3	4	5	6	7
Tremor or shaking	1	2	3	4	5	6	7
Muscle twitching	1	2	3	4	5	6	7
Confusion, spaciness, inability to concentrate	1	2	3	4	5	6	7
Memory problems	1	2	3	4	5	6	7
Slurred words, difficulty finding words	1	2	3	4	5	6	7
Coordination difficulties	1	2	3	4	5	6	7
Visual changes	1	2	3	4	5	6	7
Dizziness when standing up	1	2	3	4	5	6	7
Itchy, watery eyes or nose	1	2	3	4	5	6	7
Ringing ears	1	2	3	4	5	6	7
Nasal symptoms (discharge, stuffiness) burning (circle)	1	2	3	4	5	6	7
Sinus discomfort	1	2	3	4	5	6	7
Throat discomfort (soreness, tightness) burning (circle)	1	2	3	4	5	6	7
Weak voice, hoarseness	1	2	3	4	5	6	7
Swollen glands	1	2	3	4	5	6	7
Coughing	1	2	3	4	5	6	7
Chest discomfort (heaviness, pain) (circle)	1	2	3	4	5	6	7
Chest tightness	1	2	3	4	5	6	7
Wheezing	1	2	3	4	5	6	7
Fatigue (unusual)	1	2	3	4	5	6	7
Muscle discomfort, Spasm	1	2	3	4	5	6	7
Joint discomfort	1	2	3	4	5	6	7
Difficulty/discomfort swallowing	1	2	3	4	5	6	7
Reflux of stomach acid/burning	1	2	3	4	5	6	7
Nausea, vomiting	1	2	3	4	5	6	7
Bloating, gas	1	2	3	4	5	6	7
Abdominal discomfort (pressure, pain, cramps)	1	2	3	4	5	6	7
Shakiness relieved from eating	1	2	3	4	5	6	7
Poor appetite	1	2	3	4	5	6	7
Sweet Craving	1	2	3	4	5	6	7
Rapid pulse palpitations	1	2	3	4	5	6	7
Swelling of ankles	1	2	3	4	5	6	7
Bruising without a cause	1	2	3	4	5	6	7
Flushing skin	1	2	3	4	5	6	7
Reduced bladder control	1	2	3	4	5	6	7
Need to pass urine frequently	1	2	3	4	5	6	7
Insomnia	1	2	3	4	5	6	7
Frequent jerking in sleep	1	2	3	4	5	6	7
Loud snoring in sleep (ask spouse)		2	3	4	5	6	7
Stopping breathing in sleep (ask spouse)	1	2	3	4	5	6	7
Unwanted falling asleep during daytime	1	2	3	4	5	6	7
Menstrual changes (women)	1	2	3	4	5	6	7

13. Continued If you have had the problem in the last year, circle the number that best describes how often the symptom occurs.

Symptom	Daily to Almost Daily	Several Times/ Week	Once A Week	Several Times/ Month	Once/ Month or Less	Rarely If Ever	Not Sure
Impotence, reduced ability for erection (men)	1	2	3	4	5	6	7
Significantly reduced sex drive	1	2	3	4	5	6	7
Pain, burning, soreness in genital area **(circle)**	1	2	3	4	5	6	7
Painful intercourse or other sexual problems	1	2	3	4	5	6	7
Symptoms with loud noise, certain sounds	1	2	3	4	5	6	7
Eyes very light sensitive	1	2	3	4	5	6	7
Eyes very dry	1	2	3	4	5	6	7
Skin very dry	1	2	3	4	5	6	7
Mouth very dry	1	2	3	4	5	6	7
Unusual thirst	1	2	3	4	5	6	7
Cold/heat intolerance **(circle)**	1	2	3	4	5	6	7
Fingertips turning white or blue **(circle)**	1	2	3	4	5	6	7

Others (specify): ______________________________

____

____

14. Before your current illness, were you ever diagnosed with a psychiatric disorder?
No Yes Not Sure
IF YES, please describe: ______________________________

____

____

IF YES, were you hospitalized for it?
No Yes, when: ______________________________

15. Have you ever had: gall bladder removal **No** **Yes** gall stones **No** **Yes**
other gall bladder problems **No** **Yes (describe)** ______________________________

Do you have bloating or other difficulty digesting foods with some fat/oils in general? No Yes Not Sure

Describe any symptoms: ______________________________

____

16. Would you have limitations if you did work that required you to do the following (eg over a daily 8 hr day)?:

a. Lift and carry: No Limitation Limited

If you were asked to spend up to a third of your workday lifting and carrying, what is the maximum number of pounds that you could lift and carry without pain/fatigue? __________

b. Stand and/or walk: No Limitation Limited
How long can you do this at a time? ______hours How long can you do this total daily? _____hours

c. Sit: No Limitation Limited
How long can you sit in an office chair at a time? __________hours
How long total in a work shift? ___________hours

d. Push and/or pull (include hand and foot controls): No Limitation Limited (describe)

Describe other limitations: ______________________________

____

____

17. Does your medical condition interfere with your ability to do any of the following: Check the appropriate box. IF it doesn't apply to you, check "N/A" (Not Applicable). Also describe any problems.

	No	Yes, A Little	Yes, Moderately	Yes, A Lot	N/A	DESCRIBE PROBLEMS OR SYMPTOMS, THAT CAUSE LIMITATIONS:
a. Climbing stairs						
b. Sitting longer than one hour						
c. Standing longer than one hour						
d. Frequent bending						
e. Frequent twisting						
f. Thinking clearly while reading						
g. Thinking clearly while doing simple arithmetic						
h. Remembering and following instructions						
i. Writing/typing over one hour						
j. Driving a car in heavy traffic						
k. **Household chores:**						
Scrubbing Floors						
Washing windows/car						
Vacuuming/sweeping						
l. Carrying groceries, 10-15 lbs.						
m. Going to public places						
n. Frequent lifting, 5-10 lbs.						
o. Frequent walking (short distances)						
p. Interacting with people						
q. Maintaining regular work schedule						

18. Do you have **persistent or relapsing chronic fatigue**? No Yes

a. If yes, when did this start? Approximate date ____________ No Yes Not Sure

b. Do you have fatigue without exerting yourself? No Yes Not Sure

c. Does rest largely daily to relieve your fatigue? No Yes Not Sure

d. Has your fatigue resulted in substantial reduction in previous levels of occupational and social activity? No Yes

If YES describe ____

____

____

____

19. If fatigue is present, what factors or types of activities bring on fatigue, and how soon after starting the activity does the fatigue begin (describe)?

____

____

20. If fatigue is present, how long must you rest before you can engage in activities again? ________________________

21. Do you feel worse after exercise and exhausted the next day? No Yes

22. **In the last year**, are you : Much better A little better Same
A little worse Much worse

23. On most days, do you usually feel**:**

Fairly well with no severe symptoms, able to do all normal work/housework.
Mildly ill with few if any severe symptoms, able to do almost all normal work/housework.
Moderately ill with some severe symptoms, unable to do normal work/housework.
Very ill with many severe symptoms, unable to do normal work/housework

24. Describe your **activities for a relatively typical day** in the past month.

____

____

____

25. a. Have you noticed symptom increases when using or near the use of telephones, cell phones, remote control devices or answering machines? No Yes Not Sure
(If you only experience this with devices that are less than a year old and plastic, indicate [circle] this.)

b. Have you reacted to other electrical or electronic devices? No Yes Not Sure

26. Have you ever been in a **hospital overnight** (in-patient)? No Yes

Name of Hospital	City	Year	Medical Problem(s)

27. If you have had any of the following medical problems, **circle them and write the year or years** that the problem was present. If it is still present, put "TO NOW" after the year it started.

Adrenal Insufficiency	________	Hay Fever	________	Pneumonia	______
Alcohol Problem	________	Heart Disease	________	Polycythemia Vera	______
Anemia, Hemolytic	________	Herpes	________	Polymyositis	______
Anemia, Iron Deficiency	________	Blood Pressure	________	Porphyrin Disturbance	______
Anemia, Pernicious	________	HIV	________	Rheumatoid Arthritis	______
Arthritis	________	Hormone Deficiency	________	Scleroderma	______
Asthma	________	Hyperactivity	________	Seizures	______
Attention Deficit Disorder	________	Kidney Infections	________	Sinus Problems	______
Autoimmune Problem	________	Liver Disease	________	Sjogren's Disease	______
Bladder Infections	________	Low Blood Sugar	________	Smell Reduction	______
Chronic Fatigue	________	Lupus	________	Thromboangitis Obliterans	______
Chronic Hepatitis	________	Lyme	________	Thrombocytopenic Purpura	______
Cirrhosis (of liver)	________	Migraine	________	Thyroid, Overactive	______
Colitis, Ulcerative	________	Mitral Valve Prolapse	________	Thyroid, Under active	______
Crohn's Disease	________	Multiple Sclerosis	________	Thyroiditis (Hashimoto's)	______
Diabetes	________	Myasthenia Gravis	________	Vasculitis	______
Eczema	________	Nutritional Deficiency, Type	________	Vitamin Deficiency, Type	______
Epilepsy	________	________________	________	________________	______
"Fibromyalgia"	________	Ovarian Cyst	________	Yeast problem	______
Frequent Infections	________	Ovarian Failure	________	Other (list)	______
Graves' Disease	________	Parasite Infection	________		

	Yes	No	Not Sure
28. Has your urine ever been brown green **OR** pink-red (not due to blood)	____	____	_____
IF YES, was this shortly after an exposure that increased your symptoms?	____	____	_____
IF YES, when was the last time? Approximate Date: ________________			
29. Are your symptoms often made worse by medications?	____	____	____
30. Have you had exposure to black mold (stachybotris) at home work or school? If YES, describe (use separate paper if needed).	____	____	____

____

____

____

31. Have you ever **smoked cigarettes**? No Yes

IF YES, what year did you begin? ________________ How many packs a day on average? ______/day

Have you stopped smoking? No Yes **IF YES,** what year did you stop? ______________

32. (Women Only) Have you ever taken birth control pills? No Yes

If Yes: how long ________________________________ when_______________________.

33. Do you experience increased mood swings or irritability with your illness compared to before? No Yes

IF YES, is this greater before breakfast in morning and/or in late afternoon on an empty stomach?

No Yes Not Sure

IF NOT SURE, Please complete a mood swing diary, listing the date, time of day and the number of hours since last meal or snack-indicate for **episodes of sudden or unexpected sadness or irritability**, for at least a week or 6 episodes, and bring to office to discuss with us.

34. If you have been diagnosed with an **allergy or intolerance** to any of the following, please enter the year that the condition began or was diagnosed:

Foods ___________ Types of foods ____

Molds ____________ Pollen ______________ Dander _______________ Dust _______________

List Other allergies (include medications): Since what year? ____________________________________

____

____

35. Do you purchase foods grown without pesticides? (Sometimes called "Organic")?

Yes No Yes, sometimes Yes, regularly

36. List below what you ate & drank each meal for the last 4 days before your appointment with Dr. Ziem.

	Breakfast	Lunch	Dinner	Other
Day 1				
Day 2				
Day 3				
Day 4				

37. ON AVERAGE, how many times a day do you now drink**:**

Coke/Cola _______ day Tea (exclude herbal)_______day Coffee_______day

Total caffeine-containing beverages a day ______

38. Do you drink beer, wine, or other drinks containing alcohol? No Yes

IF YES, about how many drinks on average in a week? _____________

39. Make a list of your **questions and your goals** for this visit. Use extra paper if needed.

Questions:

____

____

____

Goals:

____

____

WORK/SCHOOL ENVIRONMENT: (If you have exposures at school but not work, describe here)

40. **Beginning with your most recent job/school,** list the years you were at them, and any chemicals you were exposed to while there. In the column marked "Sick at work/school", write **YES** if you had (or have) an illness that you think was made worse by exposures there. You should also write **YES** if your health was (is) worse at work/school than away from there. Enter a "**?**" if you don't know and "**NO**" if you don't think your hob/school made (or is making) you ill. **IF SCHOOL**, please circle school.

Employer/Type of School/Work	Years	Chemicals near you?	Sick at work/school Yes/No

41. Did you **leave your last work/school** (circle which one) **due to illness**? No Yes, when: ________________

42. Do you believe your **current work or school could or did cause/aggravate health problems**?
No Yes Not Sure

IF YES, complete the following:

Employer Company/School Name: ____________________

Supervisor/Principal Name: ____________________

Director/Manager/Owner/Teacher Name: ____________________

Employer/School Address (Include Zip Code): ____________________

Where any co-workers/classmates ill? No Yes Not Sure

Your exact work/classroom area: ____________________

Department: ____________________ Building: ____________________

43. **If you believe your current work or school is aggravating your health**, list what symptoms, if any, are worse there, and discuss exposures that you believe have affected you, and how.

44. Are any chemical **pesticides** (excluding boric acid) used?:

	No	Yes/Date Used	Not Sure	Not Applicable
In your home:				
At your work:				

At your school:				

IF YES approximate date of most recent use ______________________________

45. Have you ever asked your employer/school to reduce exposures on/in your job/school because of your symptoms? **(Bring any documentation you have.)** No Yes

Describe what you requested, with whom you spoke (name, phone #) and their response:

____

____

46. Have you ever been around any of the following frequently, regularly or in large amounts in your work place, school or at home? **IF YES,** circle the item and **write the year**(s) that you were around it in the blank. Write "**To Now**" if you are still around it. **If not sure,** put a question mark beside the item.

Adhesives, sealers	______	Paints	______	New carpet	______
Toxic waste site	______	Landfill	______	Solvents, thinners	______
Exhaust fumes	______	Pesticides	______	Cigarette smoke	______
Contaminated water	______	Lubricants	______	Cleaning agents	______
Sick/tight bldg	______	Degreasers	______	New furniture	______
Copy machine	______	Carbonless paper	______	Mold	______

Other (list type & dates ____

47. Home Environment

Check below all that apply to your home	Yes	No	Not Sure
Live in apartment/condo			
Chemical exposures from			
Pesticides used in building			
Live in mobile home			
Live in detached house you own			
Windows hard to open			
Near busy road			
Attached garage			
Household carpet			
Damp basement			
Mold in your house			
Nearby lawn chemicals used			
Plastic furniture			
Plywood furniture			
Particle board items			
Pressboard items			
Recent painting			
Recent remodeling			
Recent pesticide use			
Gas furnace			
Oil furnace			
Gas stove			
Gas water heater			
Gas clothes dryer			
Fuel space heater (not electric)			
Wood stove			
Symptoms w/family exposures			
Humidifier - regular water used			
Humidifier - filtered water used			
Well water – no chemicals			

Check all that apply to your	**Yes**	**No**	**Not Sure**
Bedroom			
Carpet			
Synthetic Rugs			
Windows open at night			
Plastic items			
Particle board furniture			
Mattress – commercial			
Pillow – foam/synthetic			
Bedding – regular commercial			
Pillow – cotton/natural			
Mattress – cotton no			
Bedding – natural			
Foam stuffed animals, toys			
Books, printed matter			

Is there an activated charcoal filter in your……

Brand(s) ______________________

	Yes	No	Not
Bedroom			
Living area			
Eating area			
Car			
Drinking water			
Shower			
Whole house water			
Whole house air			
Electrostatic/ionizing filter			
Ozone generator			
Any other problems			

Well water – chemicals added	___	___	___	___
Teflon cookware	___	___	___	___
Aluminum cookware	___	___	___	___

48. Do you recall any exposures in your past that may have left long standing (“biopersistent”) chemicals in the body? Examples are below:

- A Mosquito/pesticide truck spraying in the 1980‘s or before?
- A Chlordane or other termite/pesticide home treatments in the mid 1990’s or before?
- A DDT exposure at any time (mosquitoes, farms, other)?
- A Agricultural or other pesticides in the 1980‘s or before?
- A Agent orange or other chemical warfare poisons?
- A Mosquito/pesticide truck spraying in the 1980‘s or before?
- A Other? If YES: Describe type, duration and other exposure information in detail. Use separate sheet if necessary. ______________________________

____
____
____

49. Have you sorted all your household products and eliminated pesticides, petrochemicals, and other irritating substances from your home? No Yes, some Yes, almost all

50. Is there anyone in your home/dwelling unit who uses products that seem to aggravate your symptoms?

No Yes

IF YES, please describe situation: ______________________________

____
____
____
____

51. Do you have a nearby non-toxic outdoor area**,** such as a large park or other wooded area, where you can walk without aggravating your symptoms? No Yes Not Sure

IF YES, are pesticides ever used in these locations? No Yes Not Sure

IF NOT SURE, please ask the owner/manager of the property before your visit.

52. How many hours a week, on average, are you outside in a non-toxic area? _________ hours

53. Are you doing sauna treatments?

No Yes, at home (Brand-______________________________)
Yes, commercial sauna Yes, sauna at medical facility

54. Are you exposed to anything else of concern to you in your neighborhood?

No Yes, of concern Yes, seems to make me sick

Traffic Lawn chemicals Wood smoke Near by fabric softener Other pollution

IF YES, please describe:

Describe concerns: ______________________________

____
____
____

(OVER)

55. What other problems do you face with your health, if any: physical, emotional, social, financial, sexual, legal, etc.

56. Make a list of your questions and goals for this visit. Use extra paper if needed.

Goals

Questions