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QUICK ENVIRONMENTAL HEALTH QUESTIONNAIRE

Name ______________________ Date __________ Date of Birth _______ Age _______
Address ____
Home Phone: ______________________ Work Phone ______________ Cell Phone ______________

MEDICAL

1. Have you had a **burning-like feeling in eyes, nose, throat, lungs, other areas**: (circle) ☐ No ☐ Yes ☐ Not Sure
If yes, when first occurred? ______________________________________

2. For each situation described below, answer the questions at the top of each column. By "sick", we mean anything **YOU** consider to be either a major or 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.In a room sprayed with pesticides 4 hrs ago										
d.Next to person wearing cologne/ perfume										
e.Shopping in an enclosed mall										

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. For the symptoms and health problems listed below: Circle the number that best describes how often the symptom occurs. **Also circle** specific symptoms when several are listed.

Daily/ 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
Confusion, spaciness, inability to concentrate (**circle**)						
1	2	3	4	5	6	7
Memory problems						
1	2	3	4	5	6	7
Sinus, nose, throat irritation/burning, ear congestion (**circle**)						
1	2	3	4	5	6	7

Daily/ Almost Daily	Several Times/ Week	Once A Week	Several Times/ Month	Once/ Month or Less	Rarely If Ever	Not Sure
Chest tightness, irritation or burning (**circle**)						
1	2	3	4	5	6	7
Fatigue (unusual)						
1	2	3	4	5	6	7
Bloating, gas, abdominal discomfort (**circle**)						
1	2	3	4	5	6	7
Insomnia						
1	2	3	4	5	6	7

Questions 2 and 3 were assembled from a longer questionnaire used for research by Johns Hopkins (A. Davidoff).

4. In the last year, are you : ☐ Much better ☐ A little better ☐ Same
☐ A little worse ☐ Much worse

5. On most days, are you:
☐ Fairly well, able to do all normal activities. ☐ Moderately ill, unable to do normal activities.
☐ Mildly ill, able to do most activities. ☐ Very ill, unable to do many activities.

6. Describe what you do on a **fairly typical day**. ______________________________________

____

7. Are your symptoms now worse at work, school or home? ☐ No ☐ Yes(**circle location)** ☐ Not Sure
IF YES: List symptoms that are worse there, and exposures you believe have affected you. Use extra paper if needed. ______________________________________

____

____

____

____

8. Did you **leave your last work/school due to illness**? ☐ No ☐ Yes **If yes, when?** ______________________________
If yes, discuss exposures, symptoms ____

____

9. Have you ever been around any of the following **frequently or in large amounts** in your work place, school or home?
IF YES:
a. **Write the year**(s) you were around it in the blank.
b. **Put an X by any that caused symptoms when exposed.**

Adhesives, sealers	________	Copy machine	________	Solvents	________	Cleaning agents	________
Toxic waste site	________	Paints	________	Carbonless paper	________	New furniture	________
Exhaust fumes	________	Landfill	________	New carpet	________	Mold	________
Contaminated water	________	Pesticides	________	Solvents, thinners	________	Other list type/dates	________
Sick bldg/home	________	Lubricants	________	Cigarette smoke	________	______________________	

10. Home Environment

Check below all that apply to your home	**Yes**	**No**	**Not Sure**
Pesticides used in home/on lawn	____	____	____
Pesticides used in building	____	____	____
Nearby lawn chemicals used	____	____	____
Nearby traffic/vehicle exhaust	____	____	____
Near busy road	____	____	____
Nearby chimney/other smoke	____	____	____
Windows hard to open	____	____	____
Household carpet	____	____	____
Damp basement	____	____	____
Mold/mildew in your house	____	____	____
Humidifier – standing water	____	____	____
Symptoms w/family exposures	____	____	____
Recent remodeling	____	____	____
Recent pesticide use	____	____	____
Gas furnace or fireplace (**circle**)	____	____	____
Gas stove, dryer (**circle**)	____	____	____
Gas water heater	____	____	____
Fuel space heater (not electric)	____	____	____
Wood stove/open fireplace	____	____	____

Check all that apply to your bedroom	**Yes**	**No**
Carpet	____	____
Candles	____	____
Scented Items (more than a few)	____	____
Plastic items (more than small amount)	____	____
Particle Board Furniture	____	____
Foam items (stuffed toys, etc)	____	____
Books, Printed Matter (more than a few)	____	____
Recent Synthetic Mattress	____	____
Recent Foam/Synthetic Pillows	____	____

Do you have hazardous products such as:

	Yes	**No**	**Not**
Electrostatic/ionizing filters	____	____	____
Ozone generator	____	____	____
"Air freshener" Products	____	____	____
"Aromatherapy" Products	____	____	____
	____	____	____

Any other problems? ______________________________

____

11. Are you exposed to anything else of concern to you in your neighborhood or condo/apartment complex?
☐ No ☐ Yes
If yes, list ____

____

____

12. Do you have a nearby non-toxic outdoor area**,** such as a large park or other wooded area, where you can walk without an increase in your symptoms? ☐ No ☐ Yes ☐ Not Sure
13. How many hours a week, on average, are you outside in a non-toxic area? _________ hours

If you have illness/concerns about the above issues, consider the book Less Toxic Alternatives by health educator Carolyn Gorman (800-428-2343).