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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.

Exposures:	Would you be sick if you had to spend 4 hours.....?					Would you be sick if you had to spend 20 minutes				
	No	A Little	Moderately	A Lot	Don't Know	No	A Little	Moderately	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	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	Chest tightness, irritation or burning (circle)	1	2	3	4	5	6	7
Confusion, spaciness, inability to concentrate (circle)	1	2	3	4	5	6	7	Fatigue (unusual)	1	2	3	4	5	6	7
Memory problems	1	2	3	4	5	6	7	Bloating, gas, abdominal discomfort (circle)	1	2	3	4	5	6	7
Sinus, nose, throat irritation/burning, ear congestion (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. _____

