

ENVIRONMENTAL EXPOSURE QUESTIONNAIRE

Name: _____

Date: _____

A. METABOLISM OF POLLUTANTS:

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? Yes No
 - a) If so, what happened with which medicine? _____

B. TOXICANT RELATED HEALTH PROBLEMS:

1. Do you have a sudden onset of physical, mental or emotional symptoms (headaches, skin rashes, nausea, fatigue, shortness of breath, etc.) on exposure to chemical odors (cleaners, perfumes, new materials, cigarette smoke, diesel exhaust, etc.)? Yes No
 - a) When did you first notice any such reaction? (age you were when it began) _____
 - b) What was the chemical you first reacted to? _____
 - c) In the last 6 months are your chemical reactions getting
 - Better
 - Worse
 - Staying the same
 - d) Do you experience unpleasant symptoms when you walk down the soap aisle in the grocery store, or do you find yourself avoiding the soap aisle all together? Yes No
 - e) List the chemicals that you react to and the approximate age you were when it began:

<u>Age</u>	<u>Age</u>
<input type="checkbox"/> _____ Cleaners	<input type="checkbox"/> _____ New carpet or fabric
<input type="checkbox"/> _____ Perfumes	<input type="checkbox"/> _____ Plastics
<input type="checkbox"/> _____ Cigarette smoke	<input type="checkbox"/> _____ Pesticides or other agricultural chemicals
<input type="checkbox"/> _____ Vehicular exhaust	<input type="checkbox"/> _____ Other (list) _____
<input type="checkbox"/> _____ Paints	
2. For any of the following illnesses that you have had please note the age at which it began:

<u>Age</u>	<u>Age</u>
<input type="checkbox"/> _____ Asthma	<input type="checkbox"/> _____ Parkinsonism
<input type="checkbox"/> _____ Allergies	<input type="checkbox"/> _____ Tremors
<input type="checkbox"/> _____ Rheumatoid arthritis	<input type="checkbox"/> _____ Adult onset diabetes
<input type="checkbox"/> _____ Lupus	<input type="checkbox"/> _____ Infertility
<input type="checkbox"/> _____ Sjogren's syndrome	<input type="checkbox"/> _____ Low testosterone
<input type="checkbox"/> _____ Autoimmune thyroiditis	<input type="checkbox"/> _____ Hypothyroid
<input type="checkbox"/> _____ Any other auto immune illness	<input type="checkbox"/> _____ Gout
<input type="checkbox"/> _____ Balance disorder	<input type="checkbox"/> _____ Gestational diabetes
<input type="checkbox"/> _____ Brain fog – diminished cognition	<input type="checkbox"/> _____ Gestational hypertension
<input type="checkbox"/> _____ Memory loss	<input type="checkbox"/> _____ Overweight
<input type="checkbox"/> _____ Depression or anxiety	

C. POLLUTANT EXPOSURE:

Air Pollution

	1-5	5-10	10-20	20-30	more than 30	don't know
1. How many minutes-drive is it from your house to the closest highway/freeway?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How many minutes-drive is it from your house to a busy street or boulevard?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How many minutes-drive is it from your house to the closest agricultural area?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How many minutes-drive is it from your house to the closest industrial area where you see smokestacks?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How many minutes-drive is it from your house to the closest golf course?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How many minutes-drive is it from your house to the closest landfill?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How many years have you lived in a city, town or state that is known for its air pollution (like Los Angeles or Salt Lake City).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. How often can you “see the air” in your area? 1-4 times monthly most of the time
 all of the time rarely
9. Do you have air purifiers in your home? Yes No
 Ozone
 Ion generator
 HEPA
 IQ Air, Blue Air, Austin Air, Aller Air or similar multi-filter purifier
10. Are shoes worn inside your home?..... Yes No
11. Do you have an attached garage that your car is parked in? Yes No
12. Do you drive a diesel vehicle?..... Yes No
13. Does your vehicle have an exhaust leak?..... Yes No Unknown
14. Approximate year or decade current home was built?..... _____
15. Type of appliances (stove and hot water heater):
 Electric
 Natural gas

16. Type of heating:

- Electric
- Gas
- Oil
- Wood
- Diesel

17. When were your air ducts last cleaned out? _____

18. When was your furnace filter last replaced?

- Within the last month
- Within the last 3 months
- Don't know

19. Are pesticides used in your home or yard?..... Yes No

20. How often do you have clothes dry cleaned?..... Weekly Monthly
 Every 3-6 months Rarely/Never

21. How often do you get hair coloring? Monthly Every 3-6 months
 Rarely/Never

22. How often are you in a salon in which acrylic nail service is provided?..... Weekly Monthly
 Every 3-6 months Rarely/Never

23. Do you sleep on any of the following?

- Pillow-top mattress
- Memory foam mattress
- Memory foam pillow

24. Do you use spray or plug-in air fresheners in your home? .. Yes No

25. Have you ever worked at a job, or did schooling, that brought you in contact with industrial chemicals? Yes No

a) How many years? 1-5 5-10 10-20 20-30
 more than 30

b) What chemicals? _____

26. Have you lived in a new home or a recently remodeled home? Yes No

a) What was your age when living there? _____

27. What are the newest pieces of furniture you have purchased for your home? _____

a) When were they purchased?..... _____

b) Are any upholstery or drapes in the home treated with Scotchguard (stain resistance)?..... Yes No

28. Does your current home have wall-to-wall carpeting? Yes No

a) How old is the carpeting?..... 1-5 years 5-10 years over 10 years

b) Is it treated with Scotchguard (stain resistance)?..... Yes No

29. Are non-stick Teflon pans used for cooking in your home? . Yes No

30. Do you have any hobbies that requires the use of solvents, paints, gasoline or lead? Yes No

List

31. Do you have pets in your home that you apply anti-flea or tic products to? Yes No

a) If so, how often: Daily Weekly Monthly
 Less than once a month

D. FOOD POLLUTION

	Rarely/ never	Less than once weekly	Once weekly	Twice or more weekly
1. How often do you consume the following?				
a) Tuna.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Salmon (Chilean, Norwegian, BC or "just plain salmon").....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Alaskan salmon (one or more of the following: King, Coho, Sockeye, Red or Pink)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Swordfish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Chilean Sea Bass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Orange Roughy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Sardines.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How often do you consume (eating or juicing) commercial varieties (non-organic) of any of the following:				
a) Apples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Celery.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Cherry tomatoes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Cucumber.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Grapes (Imported)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Nectarines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Peaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Potatoes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Snap peas.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Spinach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Strawberries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Sweet bell peppers (any color).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Rarely/ never	Less than once weekly	Once weekly	Twice or more weekly
3. How often do you consume canned soup?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often do you make pre-packaged "microwave safe meals"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How often do you microwave food in styrofoam or non-ceramic "microwave safe" plastics?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often do you consume dark green leafy vegetables?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. METALS

1. Were you raised in a smoking household? Yes No
2. Have you ever smoked?..... Yes No
 - a) How many packs a day?..... less than 1 1 more than 1
 - b) How many years? 1-5 5-10 10-20 20-30
 more than 30
3. Have you lived in a home that was built before 1978? Yes No
4. Have you remodeled a home that was built before 1978? Yes No
5. Have you ever had silver amalgams in your teeth?..... Yes No
 - a) Total number: 1-3 4-6 7 or more
 - b) How many years have they been in your mouth? 1-5 5-10 10-20 20-30
 - c) How many years ago was the most recent amalgam put into your mouth? 1-5 5-10 10-20 20-30 yrs
 - d) Do you grind your teeth at night? Yes No Unknown
6. How often do you consume tofu? Rarely/never weekly less than once weekly
 once weekly twice or more weekly
7. Do you use filtered water for drinking and cooking? Yes No
 - Brita (or similar charcoal filter device)
 - Under counter multi-cartridge filter
 - R/O
 - Alkaline
 - Other (list)

F. MYCOTOXINS

	Current residence		Past residence	
1. Have you had any of the following in your current or past residence?				
a) A roof leak?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Water in the basement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Broken water pipe?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Window leaks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) Does your carpet ever get wet when it rains?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) Any water stains on ceilings or walls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g) Ever received insurance money for water in the home?..	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h) Ever needed assistance to clear water from your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i) Any rooms in the home that smell musty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
j) Do you suspect that your home has mold in it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
k) Do you have a front-loading washer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
l) Is any amount of mold visible around the shower/tub or sinks in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is your home water supply from a well or cistern?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

G. LIFESTYLE POLLUTANTS

1. Do you have any silicone containing implants?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
a) How many years ago were the implants put in?.....	<input type="checkbox"/> 1-5	<input type="checkbox"/> 5-10	<input type="checkbox"/> 10-20	<input type="checkbox"/> 20-30 yrs
2. Do you have any implants of other materials (Teflon, stainless steel, etc.)?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
3. How often do you use the following personal care products?	Rarely / Never	Less than once weekly	Daily	More than once daily
a) Skin lotion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Sunscreen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Scented deodorant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Cologne or perfume	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In your home, do you have any of the following:				
<input type="checkbox"/> WIFI routers				
<input type="checkbox"/> Bluetooth appliances				
<input type="checkbox"/> Smart meter				
<input type="checkbox"/> Cordless phones				

H. 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 use the appropriate letters for each exposure as listed below.

Residence Location (city, county, state)	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?
ZIP CODE						
ZIP CODE						
ZIP CODE						
ZIP CODE						
ZIP CODE						

- A. House built pre-1978
- B. Commercial business nearby
- C. Agricultural area
- D. Within 5 min. drive of roadway with truck traffic
- E. Dry cleaned clothes kept in bedroom closet
- F. Pets sprayed, dipped or collared for fleas or ticks
- G. Use of air fresheners
- H. Regular use of chemicals (i.e., paints, cleaners; hobbies)

- I. Unfinished pressure treated lumber (outdoor play sets, decking, patio furniture)
- J. Pesticide/herbicide use – yours or your neighbors - lawns, house bugs, gardens
- K. Family members bringing home contaminants on clothes
- L. Major power lines over or near the home
- M. Attached garage
- N. Storage of gasoline, solvents, etc., in garage

- O. Tobacco smoke (you or someone in house smoked)
- P. New construction, remodeling
- Q. Mobile Home
- R. New furniture
- S. Wall to wall carpet
- T. Natural gas or oil heat
- U. Gas stove, woodstove, fireplace
- V. Water damage in home

I. 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/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?
ZIP CODE							
ZIP CODE							
ZIP CODE							
ZIP CODE							
ZIP CODE							
ZIP CODE							