

Environmental Health Center-Dallas

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HEALTH QUESTIONNAIRE

This form will become part of your medical record and the contents are confidential. It is very important to answer all questions, as this will be most helpful in evaluating your condition. Please answer the questions by checking the appropriate space or by a Yes or No answer where appropriate.

DATE: _____ DATE LAST WORKED: _____
NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ PLACE OF BIRTH: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME PHONE: _____ BUS PHONE: _____
CELL PHONE: _____ E-MAIL ADDRESS: _____
REFERRING PHYSICIAN ADDRESS: _____



REASONS FOR YOUR VISIT: _____

TREATMENT GOALS: _____

Name: _____

CHIEF COMPLAINT AND PRESENT ILLNESS

Chief Complaint: _____

List other complaints in order of severity:

- | | | | |
|----|-------|----|-------|
| 1. | _____ | 5. | _____ |
| 2. | _____ | 6. | _____ |
| 3. | _____ | 7. | _____ |
| 4. | _____ | 8. | _____ |

Date or age main symptoms first began? _____

List any major illness you have or have had and the dates, if known: _____

Have you had a birth defect? YES NO

Have you had a birth injury? YES NO

List present medications: _____

Allergy to medications: _____

Allergy to dental anesthetics: _____

PERSONAL INFORMATION

Occupation: _____

Hobbies: _____

List work history and dates (listing possible chemical exposures/dates, if any): _____

List all states and countries in which you have lived: _____

Education: _____

Name: _____

REVIEW OF SYSTEMS BY SYMPTOMS

SKIN: Check symptoms that apply: P = Past C = Current * = Upon Exposure

- | <u>P</u> <u>C</u> <u>*</u> | <u>P</u> <u>C</u> <u>*</u> | <u>P</u> <u>C</u> <u>*</u> | <u>P</u> <u>C</u> <u>*</u> |
|--|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eczema | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Redness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shingles | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Petechiae |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Edema | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cracking | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lesions | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fungus of nails |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rash | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot odors | <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> Dry/Scaly | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Roughness |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Goose bumps (permanent) | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive perspiration | |

Do you apply lotions? YES NO

List the main skin areas involved: _____

Did you have unusually severe teenage acne? YES NO

Did you have adult onset of acne? YES NO

Antibiotic given: YES NO If yes, how long: _____

Name of antibiotic: _____

HEADACHES: Check items that apply to pain and intensity: P = Past C = Current * = Upon Exposure

- | <u>P</u> <u>C</u> <u>*</u> | <u>P</u> <u>C</u> <u>*</u> | <u>P</u> <u>C</u> <u>*</u> | <u>P</u> <u>C</u> <u>*</u> |
|--|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constant | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Throbbing | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constriction | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excruciating |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pulsating | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cap-like | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Episodic | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Band-like |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sharp | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Intermitted (daily, weekly or monthly) | | |

Check the location of head pain. The head pain is located:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Front of Head | <input type="checkbox"/> Back of Head | <input type="checkbox"/> Temple | <input checked="" type="checkbox"/> Neck |
| <input type="checkbox"/> Shoulders | <input checked="" type="checkbox"/> Maxillary Sinus | <input checked="" type="checkbox"/> Frontal Sinus | <input checked="" type="checkbox"/> Eyes |

How long headaches last? Minutes Hours Days

Clears? With Treatment Without Treatment

How many? _____ How many do you have each _____ day _____ week _____ month?

Check items associated with headaches:

- | | | | |
|---------------------------------|---|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Tearing of eye | <input type="checkbox"/> Visual disturbance | <input type="checkbox"/> Chilly sensation |
|---------------------------------|---|---|---|

What do you think causes your headaches? _____

EYES: Check symptoms associated with eyes: P = Past C = Current * = Upon Exposure

- | <u>P</u> <u>C</u> <u>*</u> | <u>P</u> <u>C</u> <u>*</u> | <u>P</u> <u>C</u> <u>*</u> | <u>P</u> <u>C</u> <u>*</u> |
|--|--|--|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dry eyes | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloodshot | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Puffiness |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Burning | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crusty lids | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Floaters | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mucus | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Double vision | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sensitive to light |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sties | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Watering | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cataracts | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night blindness |

Any eye diseases? YES NO List: _____

Wear glasses or contacts? YES NO

Name: _____

EARS: Check symptoms that apply: P = Past C = Current * = Upon Exposure

- | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * |
|--|---|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hearing loss | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching inside | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Serous otitis |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Floating sensation | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nerve deafness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wear hearing aid |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eustachian block | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tubes in ears | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent infections | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sense of imbalance | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ringing/roaring |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Noise sensitive | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Plugged ears | |

Are your symptoms seasonal? YES NO If yes, which is your worse season? _____

NOSE: Check symptoms that apply: P = Past C = Current * = Upon Exposure

- | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * |
|--|---|--|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Polyps | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent colds | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itches | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Drainage |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infections | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No sense of smell | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Super sense of smell |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Post nasal drip | | | |

Are your symptoms seasonal? YES NO If yes, which is your worse season? _____

MOUTH AND THROAT: Check symptoms that apply: P=Past C=Current * = Upon Exposure

- | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * |
|--|--|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wear dentures | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tongue swollen |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore raw tongue | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lose voice | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cracked lips/corners |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck glands swell | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever blisters |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Throat/Palate itching | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Throat closes |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bad taste | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bad breath | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sleep with mouth open |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No taste | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gums bleed | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat when waking |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shiny tongue | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Snoring | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tooth Sensitive | | |

What kind of fillings, if any, do you have? _____

CARDIAC: Check symptoms you have now or have had in the past: P = Past C = Current * = Upon Exposure

- | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * |
|--|--|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heart | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlargement | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ankle swelling |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skipped beats | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pains | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Murmurs |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow Rate | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Angina | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure |

Check items that apply:

- | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * |
|--|--|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Artificial Valve(s)
Type _____ | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Defibrillator |

How far can you walk vigorously before becoming short of breath? _____

Name: _____

Symptoms caused by? _____

Which medications relieve you best? _____

Do you smoke? YES NO How many per day? _____ How long have you smoked? _____

Have you ever smoked? YES NO When did you quit? _____

RESPIRATORY: Check any symptoms you have now or have had in the past: P = Past C = Current
* = Upon Exposure

- | | | | |
|---|--|--|--|
| P C *
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tight chest
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bronchitis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma | P C *
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent coughs
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent infections
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pneumonia
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Short of breath | P C *
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Croup
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pleurisy
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night sweats | P C *
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic Cough
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Emphysema
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heavy chest |
|---|--|--|--|

Which medications relieve you best? _____

GASTROINTESTINAL: Check symptoms that apply: P = Past C = Current * = Upon Exposure

- | | | | |
|--|--|---|--|
| P C *
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloating
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ulcer
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramping
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Burning 23
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent nausea | P C *
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Good appetite
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mucus in stools
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in stools
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belch frequently
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lower gas/bloating | P C *
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor appetite
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Indigestion
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipated
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anal itching
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent vomiting | P C *
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Regurgitation
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tarry stool |
|--|--|---|--|

GENITOURINARY: Check items that apply: P = Past C = Current * = Upon Exposure

- | | | | |
|---|---|--|---|
| P C *
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pass blood
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney stones
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Impotence
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frigidity | P C *
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney disease
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed wetting
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult urination
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sex drive diminished
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble | P C *
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Burning
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cystitis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful intercourse
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bladder disease
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Have/Had Cancer
(Where _____) | P C *
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Incontinence |
|---|---|--|---|

Preferred Sexual Partner: _____ Male _____ Female _____ Both

MUSCULOSKELETAL: Check items that apply: P = Past C = Current * = Upon Exposure

- | | | | |
|-------------------|--------------------------|--------------------------|--------------------------|
| Do you have: | P | C | * |
| muscle fatigue? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| muscle pain? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| joint swelling? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| leg cramps? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| calf cramps? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| tingling in toes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Name: _____

When do you experience your pain/cramps? _____

Do you have morning stiffness? YES NO

Check diagnoses you have been given by other physicians:

<u>P</u> <u>C</u>	<u>P</u> <u>C</u>	<u>P</u> <u>C</u>	<u>P</u> <u>C</u>
<input type="checkbox"/> <input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> <input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> <input type="checkbox"/> Lupus	<input type="checkbox"/> <input type="checkbox"/> Convulsions
<input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> <input type="checkbox"/> Paralysis	<input type="checkbox"/> <input type="checkbox"/> Gout	<input type="checkbox"/> <input type="checkbox"/> Other _____

ENDOCRINE: Check items that apply: P = Past C = Current

A weight gain or loss of more than 10 pounds during the last 30 days? YES NO

A weight gain or loss of more than 10 pounds during the last 6 months? YES NO

Enlarged thyroid, goiter, over or under active thyroid? YES NO

Any previous thyroid treatment? YES NO

What type of thyroid treatment? _____

	<u>P</u>	<u>C</u>	<u>Adrenal Gland</u>
Hypoglycemia or Low blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>	Hypo adrenaline
High Blood Sugar?	<input type="checkbox"/>	<input type="checkbox"/>	Hyper adrenaline type
Treated with medication or insulin?	_____		

Oppressive fatigue?

High blood pressure?

Low blood pressure?

WOMEN ONLY: Check items that apply: P = Past C = Current

Breast Implants Type of Implants _____
Date of implantation: ____/____/____

Yearly mammography Mastectomy Breast cysts/lumps

Other breast surgery _____ Age of onset menses? _____

<u>P</u> <u>C</u>	<u>P</u> <u>C</u>	<u>P</u> <u>C</u>
<input type="checkbox"/> <input type="checkbox"/> Regular periods	<input type="checkbox"/> <input type="checkbox"/> Irregular periods	<input type="checkbox"/> <input type="checkbox"/> Yeast infections
<input type="checkbox"/> <input type="checkbox"/> Scant flow	<input type="checkbox"/> <input type="checkbox"/> Heavy flow	<input type="checkbox"/> <input type="checkbox"/> Had miscarriage
<input type="checkbox"/> <input type="checkbox"/> Use lubricants	<input type="checkbox"/> <input type="checkbox"/> Had D & C	<input type="checkbox"/> <input type="checkbox"/> Birth control method
<input type="checkbox"/> <input type="checkbox"/> Painful periods	<input type="checkbox"/> <input type="checkbox"/> Partial/Total Hysterectomy	

1. Which of the symptoms do you have before periods? _____

2. Which of the symptoms do you have during periods? _____

3. Which of the symptoms do you have at ovulation? _____

Name: _____

Age at menopause? _____

Taking which hormones? _____

Cesareans? YES NO

How many pregnancies? _____

How many children born alive? _____

How many premature births? _____

How many stillbirths? _____

How many miscarriages? _____

Any complications with pregnancies? YES NO If yes, please specify and state when? _____

Any adopted children? YES NO

NEUROLOGICAL: Check items that apply: P = Past C = Current * = Upon Exposure

- | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * |
|---|--|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Amnesia | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feel groggy | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Had shock therapy |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shaky | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unable to concentrate | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Go to pieces easily |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Withdrawn feeling | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Forgetful | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unable to reason | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unusual tension | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frustration |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Psychiatric counseling | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hospitalization | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> State of anxiety |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Depressed | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anxious | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Worried by little things |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequently keyed-up/jittery | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Had nervous breakdown | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Use tranquilizers |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Aggressive | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Misunderstood by others | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Easily flare in anger |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feeling of hostility | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Undue fatigue | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sleep walking | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Daytime sleepiness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Am a workaholic |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Have had hallucinations | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Have heard voices | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feel insecure |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Insomnia | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Extremely shy/sensitive |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Drug abuse | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cry often | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irritable |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Medication addiction | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremor | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Short-tempered |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tingling | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Weakness in limb |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot drop | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abnormal gait |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Restless legs | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Back pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Balance problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Disorientation |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Seizure | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tics | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abnormal EEG |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of feeling | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty walking |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nerve pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Paralysis | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dragging extremities |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of energy | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Short term memory loss | |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Have seriously considered suicide | | |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Often awakened by frightening dreams | | |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Family member had nervous breakdown | | |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Considered a nervous person | | |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other _____ | | |

SLEEPING: Check all items that apply: P = Past C = Current * = Upon Exposure

- | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * | <u>P</u> <u>C</u> * |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Trouble falling asleep | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Leg cramps | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Light sleep |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sound sleep | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Charley horses | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wake up refresh |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wake up groggy | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore hips | |

Name: _____

- Wake up during night How often? _____
- Wake up during night to go to bathroom How often? _____
- Take sleep medication -- name of medication? _____

How many hours do you sleep at night? _____

HISTORY

ENVIRONMENT

POLLEN: Check items that apply:

- Worse outdoors Worse on windy days Worse outdoors 7-11 a.m.

Do you have seasonal symptoms? YES NO

Which pollens bother you? _____

Do molds bother you? _____

DUST/DUST MITE: Check items that apply:

Does dusting or sweeping increase symptoms? YES NO

Does symptoms flare shortly after going to bed? YES NO

Does symptoms accentuate upon waking? YES NO

Do you experience? Productive cough Sinus Trouble Frequent cold

Are your symptoms worse when furnace goes on for the year? YES NO

MOLD: Check items that apply:

Worse outdoors between 4:30 to 8:30 p.m. Worse in a certain room

Cool evening air increases your symptoms Name it: _____

Worse when mowing or playing on the grass Worse after sundown

Symptoms worse from mid-July to late summer Flares in basement

Especially worse with north wind IT GOES BETTER

Do you ever notice mold/mildew in bathroom or basement? YES NO

HOME: Check items that apply:

Do you live in an apartment? YES NO How old? 1975

Do you live in a house? YES NO How old? _____

Other type of housing: mobile home, farm, etc.? Be specific: _____

Is there a garage attached? YES NO

Is there an abundance of vegetation immediately around your home? YES NO

Do you feel better inside or outside your home? _____

Do you feel better in a particular room or area? YES ^{EMPTY} _{ROOM.} NO

Do you feel worse in a particular room or area? YES NO

Name: _____

CHEMICALS: Check items that apply:

Do you use strong chemicals (i.e. disinfectants, bleaches, oven and drain cleaners) in your home? YES NO If yes, name them: _____

Do you use floor and furniture wax and wax remover? YES NO

Do you use pesticides in your home? YES NO If yes, name them: _____

Name: _____

Do you or have you used a lawn care company? YES NO
When was the last time? _____ How often do you have the treatments? _____

Do you regularly have your home treated for insects? YES NO
List the specific name of the chemical: _____

Have you had your home treated for termites? YES NO If yes, when: _____
List the product used: _____

PILLOW: Check items that apply:

Feather Foam Down Synthetic

MATTRESS: Check items that apply:

Water bed Conventional Futon(cotton/foam) Cotton
 Plastic covered Box spring or Innerspring

BLANKETS: Check items that apply:

Wool Quilt Cotton Synthetic Polyester Acrylic Other

ANIMALS OR PETS: Check items that apply:

(I = Inside O=Outside)

I O I O I O
 Dog Rabbits Hamster Horse
 Cat Fish Guinea pig Cattle
 Bird Other _____

Animals in Bedroom? YES NO

PLANTS: Check items that apply:

Do you have indoor plants? YES NO If yes, how many, and where: _____

FLOORING: Check items that apply:

Carpets/Rugs: Cotton Wool Synthetic
Carpets/Rugs padding: Foam Felt Straw/fiber
Tile: Vinyl Marble Terrazzo Ceramic

Name: _____

APPLIANCES: Check items that apply:

Stove _____ Gas _____ Electric Exhaust fan? YES NO
Dryer: _____ Gas _____ Electric
Refrigerator: _____ Gas _____ Electric
Water heater: _____ Gas _____ Electric Location: _____

CLIMATE CONTROL SYSTEMS: Check items that apply:

Heating:

Gas forced air Space heater (vented/unvented) Electric forced air Solar
 Electric baseboard or panel Radiator steam/hot water heat Floor furnace Coal
 Wall furnace Gas or kerosene heating unit Fireplace/Wood
 Oil forced air Other _____

Where is the furnace located? _____

Air Conditioning:

Window Unit Central Air Unit
Filters: Electrostatic Hepa Fume control Carbon
 Other _____

FURNISHINGS:

Upholstery: Cotton Synthetic **Cushions:** Foam Synthetic
 Cotton

Window Coverings:

Blinds: Metal Wooden **Draperies:** Synthetic
 Cotton

Storm Windows: YES NO **Shades:** YES NO

WATER:

Do you get your water from a well? YES NO
Is it an artesian well? YES NO
Have you had your water tested for pesticides? YES NO
Have you had your water tested for volatile organic chemicals? YES NO
Do you have a water purification system? YES NO
If yes, what kind: _____

ELECTROMAGNETIC EXPOSURE:

Do you live near a power generating station? YES NO
Do you live near an electrical distribution sub-station? YES NO
Do you live near high voltage electrical transmission lines? YES NO
Is there a power transformer in your yard? YES NO
Do you live in direct line of a TV transmitter? YES NO
Do you live near a microwave tower? YES NO

Name: _____

Do you live near a radio tower? YES NO

What type of electric lights do you have?

Incandescent Fluorescent Full Spectrum

On what type of equipment do you prepare your food?

Gas Electric Microwave

Do you notice any difference in symptoms from food prepared in a specific way?

Gas: YES NO Electric: YES NO Microwave: YES NO

Do you notice any symptoms when near the microwave oven? YES NO

Do you notice any symptoms from exposure to TV? YES NO

Do you have an antenna on your home? YES NO

Do you have cable television? YES NO

Symptoms associated with electromagnetic energy: _____

Do you work in a modern office building with computers, electric typewriters, and/or word processors, etc.? YES NO

Do you operate any of the office machines mentioned above? YES NO

Do you notice sensitivity to metal? YES NO

Do weather changes cause a change in your mental or physical health? YES NO

Do you use electric blankets? YES NO

The questions below pertain to specific substances that may be present in your home environment. It is an unwanted silent intruder whose presence may be undetected, yet its effect is powerful and its influence long lasting.

Do you have a basement? YES NO

What kind of soil does your area have? Sandy Clay Granite
 Shell Phosphate rock

What kind of material constitutes your basement floors and walls?

Solid Concrete Concrete Cinder Block Soil

Do you notice any cracks in the foundation of your basement? YES NO

What type of insulation do you have? _____

Is your home well insulated? YES NO

Has there been any mining in the immediate vicinity of your home? YES NO

Do you know the previous use of the land on which your home was built? YES NO

If yes, what was the previous use: _____

Name: _____

Have you noticed any change in your health since being in this home? YES NO

If yes, please describe: _____

Have you had your home tested for radon? YES NO

INHALANT & CHEMICAL EXPOSURES: *Check if exposed, double check if you have symptoms from:*

- | | | | |
|--------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Dust | <input type="checkbox"/> Photocopy paper | <input type="checkbox"/> Pesticides | <input type="checkbox"/> Varnish |
| <input type="checkbox"/> Varnish | <input type="checkbox"/> Overstuffed furniture | <input type="checkbox"/> Herbicides | <input type="checkbox"/> Solvents |
| <input type="checkbox"/> Lacquer | <input type="checkbox"/> Furniture polish | <input type="checkbox"/> Grain dust | <input type="checkbox"/> Mildew |
| <input type="checkbox"/> Marshy area | <input type="checkbox"/> Disinfectants | <input type="checkbox"/> Dog inside | <input type="checkbox"/> Cat inside |
| <input type="checkbox"/> Incense | <input type="checkbox"/> Floor wax | <input type="checkbox"/> Bird inside | <input type="checkbox"/> Other pets inside |
| <input type="checkbox"/> Tar | <input type="checkbox"/> Desert area | <input type="checkbox"/> Woody area | <input type="checkbox"/> Dyes |
| <input type="checkbox"/> Rubber | <input type="checkbox"/> Plastic | <input type="checkbox"/> Mothballs | <input type="checkbox"/> Paints |
| <input type="checkbox"/> Linoleum | <input type="checkbox"/> Tobacco smoke | <input type="checkbox"/> Turpentine | <input type="checkbox"/> New carpet |
| <input type="checkbox"/> Old carpet | <input type="checkbox"/> Potted plants | <input type="checkbox"/> Diesel fumes | <input type="checkbox"/> Cosmetics |
| <input type="checkbox"/> Rugs | <input type="checkbox"/> Exhaust fumes | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Perfume |
| <input type="checkbox"/> Kapok | <input type="checkbox"/> Gasoline fumes | <input type="checkbox"/> Nail polish | <input type="checkbox"/> Dry cleaning |

List family hobbies which bring on symptoms (model planes, etc.): _____

List family work exposures: _____

Symptoms: _____

MEDICATIONS TAKEN IN THE PAST: *Please list:* _____

COMMUNICABLE DISEASES: *List diseases you have had (i.e. measles, TB, mumps, etc.):*

IMMUNIZATION: *Have you ever had immunizations for?* Smallpox Tetanus
 Polio Mumps
 Other _____

Difficulty with any immunization? YES NO

If yes, please describe: _____

FOR CHILDREN ONLY:

- | | |
|---|--|
| <input type="checkbox"/> Often whiny and bad tempered | <input type="checkbox"/> Spells of intense temper and fury |
| <input type="checkbox"/> Has a finicky appetite | <input type="checkbox"/> Clumsy or poor coordination |
| <input type="checkbox"/> Has few friends | <input type="checkbox"/> Sluggish in the mornings |
| <input type="checkbox"/> Stressed out | <input type="checkbox"/> Discipline problem |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Markedly shy and timid |

Name: _____

- Has trouble sleeping
- Unable to gain weight
- Sweats about the head and neck when sleeping
- Reading problem
- Writing problem
- School grades
- Other _____

FAMILY: Check any of the following illness that occurred in your family:

- Hayfever
- Headache
- Vertigo
- Arthritis
- Emphysema
- Thyroid
- Other _____
- Hives
- High blood pressure
- Tuberculosis
- Psychiatric care
- Nervousness
- Emotional problems
- Constipation
- Low blood pressure
- Blood disorders
- Kidney disease
- Brain tumors
- Diabetes
- Cancer
- Eczema
- Asthma
- Drug Use
- Diarrhea
- Depression

If parents and/or grandparents are deceased, what was their age at the time of their death?

Parents: _____

Grandparents: _____

TREATMENT

ALLERGY: Check items that apply:

Have you ever had allergy tests? YES NO If yes, when and what type: _____

With or without preservatives? _____

With what physician? _____

Are you taking allergy injections at the present time? Yes NO

Do you frequently require emergency treatment for allergy? Yes NO

Did allergy treatments help? Yes NO

HOSPITALIZATION:

Please list all hospitalizations/surgeries and dates, if known _____

Name: _____

STUDIES: List X-rays, MRI, EEG, EKG, Blood Work, Sonograms, etc. done in the last 5 years? _____

HIV & Hepatitis Screen Results in Past 6 Months:

Doctor's Seen:

Tests

- 1. _____
- 2. _____
- 3. _____

SENSITIVITY ANALYSES

CONTACT DERMATITIS: Check items that apply:

Has your skin ever been bothered by contact with any substances? YES NO

Explain: _____

Have you ever had?

- Poison Oak Poison Ivy
- Poison Sumac Other _____

What treatment used? _____

Does wearing metal watches, rings, necklaces cause you to break out? YES NO

INSECT SENSITIVITY: Check items that apply:

List any insects to whose bite or sting you get greater than normal reaction:

Check any reaction you get:

- Anaphylaxis Large local swelling Dizziness
- Loss of consciousness Required hospitalization Nausea
- Difficulty breathing Other _____

What type of treatment do you receive after each reaction?



Is there anything else you feel we should know about you that may have contributed to your illness?

