Taking An Exposure History

A mnemonic (CH^2OPD^2) helps to organize the history, and the forms below can be given to patients to be completed at home and reviewed at a subsequent educational counseling visit.

C ommunity

H ome

H obby

O ccupation

P ersonal

D iet

D rugs

Please answer <u>all</u> questions.

Exposure History

COMMUNITY

For each of the items listed below: **Do you presently live nearby** (within 300 m- about 3 mid-sized city blocks)

Heavy traffic	☐ No	☐ Yes *(please specify)*	☐ highway	☐ busy street
Vehicle idling area	☐ No	☐ Yes *(please specify)*	☐ auto	☐ bus / truck
Dump site(s)	☐ No	☐ Yes *(please specify types)*	_____	
Areas sprayed with pesticides: ☐ No ☐ Yes *(please specify type)* e.g. Farm(s), Orchard(s), Golf Course			_____	
Industrial plant(s)	☐ No	☐ Yes *(please specify types)*	_____	
Polluted lake / stream	☐ No	☐ Yes *(please specify types)*	_____	
Nuclear power plant	☐ No	☐ Yes		
Electricity towers	☐ No	☐ Yes		
Airport	☐ No	☐ Yes *(please name)*	_____	
Cellphone towers	☐ No	☐ Yes *How many?*	_____	
Other potential hazards	☐ No	☐ Yes *(please specify type)*	_____	
Commute	☐ No	☐ Yes *How long both ways?*	_____min	*Type of transportation:* _____

If you have ever lived nearby, please write the number of years in the appropriate age group(s).

Age:	0-5	6-17	18-40	41-64	65+

Do you protect yourself from excess sun exposure? ☐ rarely ☐ occasionally ☐ often/always ☐ using clothing ☐ sun block

Use tanning bed? ☐ No ☐ Yes (*How often?*) _____ **Use tanning solutions?** ☐ No ☐ Yes (*How often?*) _____

HOME & HOBBY

How long have you lived in your present residence? _____ **How old is it?** _____

Is your residence? ☐ On a First Nations reserve→*(please name)*_____ ☐ house (detached) ☐ house (semi-detached) ☐ mobile home ☐ apartment → ☐ basement # of floors___ your floor ____ On what floor is your bedroom?_____ Age of your mattress_____

Do you use dust mite-proof: Pillow cover(s)? ☐ No ☐ Yes Mattress cover(s)? ☐ No ☐ Yes

Ownership? ☐ owner occupied ☐ rental ☐ co-op ☐ public housing

How is your home heated? ☐ forced air ☐ hot water radiators ☐ space heater ☐ baseboard heaters ☐ other _____

What type of fuel is used for heating? ☐ natural gas ☐ oil ☐ wood ☐ electricity ☐ propane

Has your home or apartment building been tested for radon? ☐ No ☐ Yes

Have any renovations been done since you've moved in? ☐ No ☐ Yes → When?_____ What? _____

Do you use: ☐ central vacuum? ☐ HEPA filter vacuum? ☐ other vacuum? (*please specify)* _____

What is your water source for bathing? ☐ city ☐ well ☐ other (*please specify)* _____

What product(s) do you usually use in your home? *(please specify brands)*

bathroom cleanser _____ floor / wall cleanser _____ window cleaner _____

laundry detergent _____ liquid fabric softener _____ dryer sheets _____

For each of the items listed below, do you presently have/use:

			If you ever had, please write down the number of years in the appropriate age group(s)				
			Age:	**0-5**	**6-17**	**18-40**	**41-64**	**65+**
Basement cracks *or* dirt floor	☐ No	☐ Yes *(circle which one or both)*						
Damp, musty basement *or* crawl space	☐ No	☐ Yes *(circle which one or both)*						
Wet windows or outside closet walls (condensation)	☐ No	☐ Yes → O slight O severe						
Water leaks or water damage	☐ No	☐ Yes → O slight O severe → *Where?*						
Visible mould	☐ No	☐ Yes → O slight O severe → *Where?*						
Crumbling pipe insulation	☐ No	☐ Yes → O slight O severe						
Flaking paint	☐ No	☐ Yes → O slight O severe						
Stagnant stuffy air	☐ No	☐ Yes → O slight O severe						
Gas or propane stove	☐ No	☐ Yes *(circle which one or both)*						
Other gas appliances	☐ No	☐ Yes *(please specify)*						
Microwave	☐ No	☐ Yes						
Wood stove or fireplace	☐ No	☐ Yes *(circle which one or both)*						
Air conditioning	☐ No	☐ Yes → O central O individual rooms						
Electrostatic air cleaner	☐ No	☐ Yes						
Other air cleaner(s)	☐ No	☐ Yes *(please specify)*						
Deodorizer	☐ No	☐ Yes *(please specify)*						
Carbon Monoxide Detector	☐ No	☐ Yes → How many? _____						
Smoke detector	☐ No	☐ Yes → How many? _____						
Smoking at home	☐ No	☐ Yes → Who smoked? _____						
Smoking in car	☐ No	☐ Yes → Who smoked? _____						
WiFi / Router	☐ No	☐ Yes → When did you install? _____						
Smart meter	☐ No	☐ Yes →*Where?*_____						
Carpets	☐ No	☐ Yes →*Where?*_____ *How old?*_____						
Vinyl linoleum	☐ No	☐ Yes →*Where?*_____ *How old?*_____						
Pesticides	☐ No	☐ Yes →*Where?*_____						
Pets	☐ No	☐ Yes *(please specify kind & number)*						
Pets sleep in your bedroom	☐ No	☐ Yes						
Indoor plants	☐ No	☐ Yes → *How many?*						
Garage	☐ No	☐ Yes → ☐ attached ☐ underground						
Furniture stripping / refinishing	☐ No	☐ Yes *(please specify type)* _____						
Home renovating (hobby)	☐ No	☐ Yes *(please specify type)* _____						
Art work	☐ No	☐ Yes *(please specify type)* _____						
Other non-occupational activities with exposure to toxic chemicals (hobbies)	☐ No	☐ Yes *(please specify type)* _____						

What hobbies do members of your household have?

Do you participate in sports? ☐ No ☐ Yes *(please specify what & how often)*

_____

OCCUPATION

Do you presently do volunteer work and/or work for pay?

☐ **Yes** ☐ **No**

If yes,	☐ Volunteer work → *Number of hours per week:* _____ *Type:* _____ ☐ Work for pay → *Number of hours per week:*
If no,	☐ Unable to work for pay due to health problems → *Date stopped work:* *Reason(s):* _____ ☐ On disability benefits → ☐ ODSP ☐ CPP ☐ WSIB ☐ Other *(please specify)*_____ **OR** Disability claim ☐ *unresolved* ☐ *permanently denied*

Starting with your present or most recent job, please list all of the paying jobs you have ever had (including summer jobs). *Please use additional paper if necessary.*

* Please list the significant chemicals, dusts, fibres, fumes, radiation, biologic agents (e.g. bacteria, moulds, viruses), electromagnetic fields and physical agents (e.g. extreme heat, cold, vibration, noise) that you were exposed to at this job.

** Please list any protective measures taken (e.g. showering at work, laundering clothes at work, etc.) or protective equipment used (e.g. gloves, apron, mask, respirator, hearing protectors, etc.).

Company Name & Work Location	From Mth / Yr	To Mth / Yr	Job Title & Description	Exposures*	Protective Measures / Equipment **
1.	/	/			
2.	/	/			
3.	/	/			
4.	/	/			
5.	/	/			
6.	/	/			
7.	/	/			

Have you ever served in the military? ☐ No ☐ Yes → *when?*_____ *where?* _____

The following questions are about your present or most recent work environment:

Age of Building: _____ Number of Floors: _____ Approximate number of occupants: _____

Neighbourhood: ☐ rural ☐ commercial ☐ industrial Smoking allowed on property? ☐ No ☐ Yes

Which of the following are / were on the same floor as your work station in your present or most recent work?

☐ banks of computers ☐ WiFi ☐ unvented copy machines ☐ partitions or room dividers

☐ central air conditioning ☐ windows that open ☐ carpets → *How old?*_____ ☐ co-workers wearing perfume

☐ number of co-workers complaining of feeling ill at work _____ *Please specify symptoms* _____

Can / could you smell odours from the following in your present or most recent work environment?

☐ laboratory ☐ cafeteria ☐ manufacturing area ☐ idling vehicles ☐ parking garage

Have any of the following occurred in your work environment over the past 12 months or the last 12 months you worked in your most recent job?

☐ use of pesticides → O indoors O outdoors ☐ fire, smoke ☐ flood, water leaks ☐ carpet cleaning

☐ new flooring, furniture, etc. *(please specify)* _____ ☐ painting ☐ deodorizer use

☐ construction or ☐ renovation or ☐ chemical spill, leak *(please specify)* _____

☐ stress *(please specify)* _____

SCHOOL

(Complete this form only if you are going to school
OR if your child is the patient and is going to school)

☐ not applicable to me

Personal or Child's level of education (Please check one)

No formal schooling ☐ Some primary ☐ Completed primary ☐ Some secondary or high school ☐ Completed secondary or high school ☐
Diploma/Apprenticeship ☐ Some University ☐ Completed University degree (please specify)_____

How old is your or your child's school? _____ Number of floors: _____ Number of occupants: _____

Have additions been made to the original building? ☐ No ☐ Yes → When? _____

Number of portable classrooms in use:__ Hours per day you or your child spends in a portable classroom:_____

School neighbourhood: ☐ rural ☐ suburban ☐ urban

Is your or your child's school located near (within 300 m or about 3 city blocks) of any of the following:

Heavy traffic	☐ No	☐ Yes *(please specify)*	☐ highway	☐ busy street
Vehicle idling area	☐ No	☐ Yes *(please specify)*	☐ auto	☐ bus / truck
Dump site	☐ No	☐ Yes *(please specify type)*	_____	
Farm(s)	☐ No	☐ Yes *(please specify type)*	_____	
Industrial plant(s)	☐ No	☐ Yes *(please specify type)*	_____	
Polluted lake / stream	☐ No	☐ Yes *(please specify type)*	_____	
Nuclear power plant	☐ No	☐ Yes		
Electric towers	☐ No	☐ Yes		
Cell Towers	☐ No	☐ Yes		
Other potential hazards	☐ No	☐ Yes *(please specify type)*	_____	

Which of the following does your or your child's school have? *(Please check all that apply)*

☐ carpeted classrooms	☐ central air conditioning	☐ art room – exhaust hood?	☐ No	☐ Yes
☐ unvented copy machine(s)	☐ windows that open	☐ laboratory – exhaust hood?	☐ No	☐ Yes
☐ flaking paints	☐ mouldy smell	☐ workshop – exhaust hood?	☐ No	☐Yes
☐ laptops	☐ WiFi hubs *When installed?* _____			

Have any of the following occurred in your or your child's school during the current or last school year?
(Please check all that apply)

☐ carpet cleaning	☐ construction	☐ renovation	☐ painting
☐ new flooring or furniture *(please specify)* _____		☐ flood, water leaks	☐ roof tarring
	☐ use of pesticides / herbicides → ☐ indoors ☐ outdoors		

Are the following products used in your or your child's school during the school year?
(Please check all that apply)

☐ deodorizers	☐ furniture wax or polish	☐ odourous cleaning products
☐ deodorant sprays	☐ floor wax	☐ scented washroom soap
☐ spray paints	☐ permanent markers	☐ strong-smelling art supplies

Does your or your child's school have a policy regarding the use of personal scented products by staff and students?

☐ No ☐ Yes *(please specify)* → ☐ prohibition of scented products ☐ encouragement of unscented products

Exposure History

PERSONAL

Natural Inhalant Allergies

Have you ever had allergy tests or treatments?
(seasonal pollens, animal danders, dust, mites, or moulds)?

☐ No ☐ Yes *If **YES**, please specify below:*

Approx. Age	Approx. Year	Type of Test	Positive Results *(please specify)*	Treatments (e.g. avoidance, shots, medications)	Improvement after 1 year **0** = worse **1** = none **2** = a little **3** = some **4** = a lot

Synthetic Chemicals

Have you ever had symptoms you linked with exposure to any synthetic (man-made) chemical at a level that did not seem to bother most people?

'*Linked*' means that the symptom started or worsened within 48 hours after you were exposed to something, and/or the symptom improved or disappeared after you were no longer exposed to it.
'*Exposure*' means being near, touching, smelling, breathing in, eating, drinking, swallowing or injecting something.

☐ No If **YES**, *please specify chemical(s) and symptom(s) below (please use additional paper, if necessary).*

Man-made Chemical	Symptoms Linked with Low Level Exposure	Presently Affected? **1** = a little **2** = somewhat **3** = a lot	With avoidance, how long for symptoms to disappear? **1** = mins **2** = hours **3** = days

Do you use SCENTED personal or hair products? *(please check)* ☐ No ☐ Yes *If **YES**, please specify below:*

Scented Products	Soap	Lotion	Cosmetics	Perfume/ Cologne/ Aftershave	Hair permanent	Hair colour	Hair Spray	Other(s) *(please specify)*
Infrequently	☐	☐	☐	☐	☐	☐	☐	☐ _____
Daily	☐	☐	☐	☐	☐	☐	☐	☐ _____

Smoking History

Do you currently use tobacco (daily or almost every day)?

☐ No ☐ Yes *(please specify)* → ☐cigarettes ☐cigars ☐pipe ☐snuff ☐chewing tobacco

If **YES**, average number per day: _____ # of years: _____Interested in a smoking cessation program? ☐ No ☐ Yes

If **NO**, have you ever used tobacco (daily or almost every day)? ☐ No ☐Yes

· If **YES**, number of years you used tobacco: _____ Average number per day: _____

· Date you last used tobacco regularly: Year _____

Have you ever experimented with "recreational drugs"? ☐ No ☐ Yes → What drugs? _____
What age/s? _____

Artificial Materials

How many metal dental fillings / caps do you currently have? silver / mercury _____ gold _____

Have you had silver / mercury fillings removed? ☐ No ☐ Yes → Number removed: _____ Year(s): _____

Do you have a bridge, denture or partial plate? ☐ No ☐ Yes → Number of Year(s): _____

Do you have other artificial materials in your body? (e.g. pins, screws, plates, meshes, valves, implants, etc.)

☐ No ☐ Yes *(please specify)* _____

Do you have body art? ☐ No ☐ Yes → ☐ Tattoos → Number :_____ ☐ Piercings → Number:_____

Electromagnetic Fields ``Screen Time``

How often do you use: *(please circle)*	**Infrequently**		**Daily**			
	never/rarely	**< once/week**	**<30 min**	**1-3 hrs.**	**4-7 hrs.**	**8 hrs or more**
Cell phone	☐	☐	☐	☐	☐	☐
Cordless phone	☐	☐	☐	☐	☐	☐
Laptop computer	☐	☐	☐	☐	☐	☐
Desktop computer/video display unit	☐	☐	☐	☐	☐	☐
Remote headset	☐	☐	☐	☐	☐	☐
Wireless Devices (i.e. TV, mouse, keyboard)	☐	☐	☐	☐	☐	☐

Blood Transfusion, Immunization Reaction, Travel Illness

Have you had blood transfusion(s)? ☐ No ☐ Yes → *Year(s)*_____ Circumstances? _____

Have you had abnormal reactions to immunizations? ☐ No ☐ Yes →Type_____ *Year(s)*_____

Have you ever experienced significant symptoms when travelling? ☐ No ☐ Yes→

Please specify year, location, symptoms: _____

Living Situation / Supports / Stresses

Who lives at home with you? _____

Are you: ☐ single ☐ married / cohabitating ☐ separated ☐ divorced ☐ widowed

Do you have inner or spiritual beliefs or mindfulness activities which help you cope?

☐ No ☐ Yes *(please specify)* _____

Are you part of a social or religious community which helps you cope?

☐ No ☐ Yes *(please specify and estimate the number of contacts in the last 12 months)*_____

Who backs you up best with your present health problems? _____

What other supports do you have? _____

Type of Stress	**Ever had it?**	**When?** *Specify year(s)*	**Comments (e.g. who or circumstances involve**
Loss of someone close	☐ No ☐ Yes		
Severe illness- someone close	☐ No ☐ Yes		
Poverty (family income less than $20, 000 /yr)	☐ No ☐ Yes		
Loss of job	☐ No ☐ Yes		
Change of job or workplace	☐ No ☐ Yes		
Household move	☐ No ☐ Yes		
Marriage	☐ No ☐ Yes		
Separation	☐ No ☐ Yes		
Divorce	☐ No ☐ Yes		
Pregnancy	☐ No ☐ Yes		
Alcohol / drug addiction	☐ No ☐ Yes		
Alcohol / drug addiction in someone close	☐ No ☐ Yes		
In jail	☐ No ☐ Yes		
Physical abuse	☐ No ☐ Yes		
Emotional abuse (being put down, called names)	☐ No ☐ Yes		
Sexual abuse	☐ No ☐ Yes		
Other *(please specify)*	☐ No ☐ Yes		

Exposure History

DIET

Who grocery shops?_____ **Who cooks?**_____

Please indicate the top 3 foods, snacks, beverages and combinations you typically consume in a week (e.g. wheat cereal, sugar and milk):

Foods / Snacks /Combinations	*Please Specify*			Beverages
Breakfast	1.	2.	3.	
Mid-Morning	1.	2.	3.	
Lunch	1.	2.	3.	
Mid-Afternoon	1.	2.	3.	
Dinner	1.	2.	3.	
Evening	1.	2.	3.	

Do you eat organic food? ☐ No ☐ Yes → *circle how often:* Rarely/About once/wk/2 times/wk/Daily/Several x daily

Do you eat foods with food colouring? ☐ No ☐ Yes → *circle how often:* Rarely/About once/wk/2 times/wk/Daily/Several x daily

Do you use artificial sweetener? ☐ No ☐ Yes → On average, how many days per week?_____ How many times per day?_____

Do you eat fish or seafood? ☐ No ☐ Yes → on average, how many days per week? ____ How many times per day? _____

Type(s) of fish or seafood eaten e.g. tuna, shark, swordfish, local fish, salmon, tilapia, shrimps, oysters, other.:_____ Wild_____ Farmed____

Do you eat hunted game meat? ☐ No ☐ Yes → Type____ On average, how many days per week? ____ How many times per day? ____

How much of the following beverages do you consume regularly and have you linked any symptoms?

☐ **water** → Number of 8 oz glasses per 24 hours _____ ☐ city ☐ well water ☐ charcoal-filtered ☐ distilled ☐ reverse osmosis ☐ bottled (glass) ☐ bottled (plastic) Any symptoms linked?_____

☐ **beer, ale** → Number of 12 oz bottles per week _____ Any symptoms linked?_____

☐ **wine** → Number of 6 oz glasses per week _____ Any symptoms linked?_____

☐ **spirits** (e.g. whisky, rum, gin, vodka) → Number of 1½ oz drinks per week _____Any symptoms linked?_____

☐ **coffee** → Number of 8 oz cups per 24 hours _____ Any symptoms linked?_____

☐ **tea** → Number of 8 oz cups per 24 hours _____ Please specify type? _____ Any symptoms linked? _____

☐ **sodas**→ Number of drinks per 24 hours _____ Please specify _____ Any symptoms linked_____

☐ **cola** → Number of 12 oz drinks per 24 hours _____ ☐ regular ☐ diet Any symptoms linked?_____

☐ **energy drinks** → Number of 12 oz drinks per 24 hours __Amount of caffeine/drink__ Any symptoms linked?_____

☐ **other(s)** *(please specify)* _____Any symptoms linked?_____

Please list foods / beverages that do not agree with you (e.g. stuffy runny nose, headache, heartburn, bloating, diarrhea, sleepiness, difficulty thinking or concentrating, etc.) **or trigger allergic reactions** (e.g. hives, rashes, shortness of breath, wheezing, anaphylaxis, etc.)**:**

List foods / beverages that are a problem	What problem(s) do they give you?	With avoidance, how long for symptoms to disappear?			Approximately how often do you eat / drink them?			
		Mins	Hrs	Days	Never	Occasionally	Daily	> once a day

Please list any foods / beverages that you crave or help you to feel better:

List foods / beverages that you **crave** or help you to feel better	Time(s) of craving	What problem(s), if any, do they give you?	Approximately how often do you eat / drink them?			
			Never	Occasionally	Daily	> once a day

DRUG

Please list all PRESCRIPTION medications you currently take on a regular basis, including birth control pills and allergy injections
(please use additional paper if necessary):

Name of prescription medication	Dose (e.g. mg, ml, IU)	How often do you take it?	How long have you taken it?	If you have side effects, please specify

Have you ever taken steroids? ☐ No ☐ Yes → ☐ Nose Spray ☐ Inhaler ☐ By Mouth

Please specify when _____

Have you ever taken antibiotics for more than one month? ☐ No ☐ Yes →

List condition(s) _____ When _____ Name of antibiotic(s) _____

Have you ever used antifungals?? ☐ No ☐ Yes → ☐ By Mouth ☐ Cream/Gel ☐ Shampoo

List condition(s) _____ When _____ Name of antifungal(s) _____

Please list all NON-PRESCRIPTION medications you currently take on a regular basis, including vitamins, minerals, herbs, remedies, etc.
(please use additional paper if necessary):

Name and brand of non-prescription medication	Dose (e.g. mg, ml, IU)	How often do you take it?	How long have you taken it?	If you have side effects, please specify

Drug Adverse Reactions: Please list ANY medication / anaesthetic / immunization you have had to stop taking because of side effects or allergic reactions:

Name of medication / anaesthetic / immunization	Type of side effects or allergic reaction that caused you to stop it	Treatment of side effects or reactions	Age	Year

12. **Have you EVER had an emergency injection of adrenaline (epinephrine) for a reaction to any medication, food, insect sting, or other substance?**
☐ No ☐ Yes → What year(s) _____

To what? _____

Do you have an EpiPen or Twinject? ☐ No ☐ Yes → *When was it prescribed?*_____