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

Exposure History

COMMUNITY

For each of the items listed below:	**Do you presently live nearby**					**If you ever lived nearby, please write the years.**
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				_____
Hydro towers	❑ No	❑ Yes				_____
Other potential hazards	❑ No	❑ Yes	*(please specify type)* _____			_____

Do you protect yourself from excess sun exposure? ❑ rarely ❑ occasionally ❑ often ❑ always

HOME & HOBBY

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

What type of dwelling is your residence? ❑ house ❑ mobile home
❑ apartment ➟ ❍ basement ❍ above store ❍ highrise ➟ *floor* _____

Ownership? ❑ owner occupied ❑ rental ❑ public housing

How is your home heated? ❑ forced air ❑ hot water radiators ❑ space heater ❑ baseboard heaters

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

Do you use: ❑ central vacuum? ❑ HEPA filter vacuum? ❑ other vacuum? _____

Have you done any renovating? ❑ No ❑ Yes ➟ When? _____
What? _____

Do you own / lease a car? ❑ No ❑ Yes ➟ Age? _____ **Smoking permitted inside?** ❍ No ❍ Yes

Do you use pesticides or herbicides (bug or weed killers, flea / tick sprays, collars, powders, pellets, etc.):

① **in your home?** ❑ No ❑ Yes *(please specify type)* _____

② **on your pets?** ❑ No ❑ Yes *(please specify type)* _____

③ **on your lawn or garden?** ❑ No ❑ Yes *(please specify type)* _____

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

For each of the items listed below:	Do you presently have in your **HOME**?	If you ever had, please write the years.
Basement cracks or dirt floor	❑ No ❑ Yes *(circle which one or both)*	
Damp, musty basement or crawl space	❑ No ❑ Yes ➟ ❍ slight ❍ severe	
Wet windows or outside closet walls (condensation)	❑ No ❑ Yes ➟ ❍ slight ❍ severe	
Water leaks	❑ No ❑ Yes ➟ ❍ slight ❍ severe ➟ *Where?* _____	_____
Visible mould	❑ No ❑ Yes ➟ ❍ slight ❍ severe ➟ *Where?* _____	_____
Crumbling pipe insulation	❑ No ❑ Yes ➟ ❍ slight ❍ severe	
Flaking paint	❑ No ❑ Yes ➟ ❍ slight ❍ severe	
Stagnant stuffy air	❑ No ❑ Yes ➟ ❍ slight ❍ severe	
Gas or propane stove	❑ No ❑ Yes *(circle which one or both)*	
Other gas appliances	❑ No ❑ Yes *(please specify)* _____	
Wood stove or fireplace	❑ No ❑ Yes *(circle which one or both)*	
Carbon monoxide detector(s)	❑ No ❑ Yes	
Air conditioning	❑ No ❑ Yes ➟ ❍ central ❍ individual rooms	
Electrostatic air cleaner	❑ No ❑ Yes	
Other air cleaner(s)	❑ No ❑ Yes *(please specify)* _____	
Carpets	❑ No ❑ Yes ➟ *Where? (e.g. basement, your bedroom, etc.)* _____	
	How old? _____	
Old vinyl linoleum	❑ No ❑ Yes	
Photocopier / fax machine / printer	❑ No ❑ Yes ➟ *Type(s)?* _____	
Garage	❑ No ❑ Yes ➟ ❍ attached ❍ underground	
Smoker(s)	❑ No ❑ Yes ➟ *Who?* _____	
Pets	❑ No ❑ Yes *(please specify kind & number)* _____	
Pets sleep in your bedroom	❑ No ❑ Yes	
Indoor plants	❑ No ❑ Yes ➟ *How many?* _____	

Do you use an electric blanket? ❑ No ❑ Yes ➟ *Years* _____

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

Age of your mattress _____

What product(s) do you usually use: *(please specify brands)*

bathroom cleanser _____ floor / wall cleanser _____

laundry detergent _____ fabric softener _____

What hobbies do you have? _____

What hobbies do members of your household have? _____

Have you ever personally done any of the following:

❑ furniture stripping / refinishing Years: _____

❑ home renovating Years: _____ *(please specify type)* _____

❑ art work (e.g. painting, ceramics, stained glass, leather work, etc.) Years: _____ *(please specify type)* _____

❑ other non-occupational activities with exposure to toxic chemicals

Years: _____ *(please specify type)* _____

OCCUPATION

1. **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 ➟ *Type:* _____ **OR** Disability claim ➟ ❑ *unresolved* ❑ *permanently denied*

2. **Starting with your present or most recent job, please list all of the paying jobs you have ever had.**
Please use the back of this page if necessary.

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

* Please list the significant chemicals, dusts, fibres, fumes, radiation, biologic agents (e.g. bacteria, moulds, viruses) 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.).

3. **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

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

❑ bank of computers ❑ partitions or room dividers ❑ unvented copy machines
❑ unvented smoking areas ❑ carpets ➟ *How old?* _____
❑ central air conditioning ❑ windows that open

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

❑ laboratory ❑ cafeteria ❑ manufacturing area ❑ parking garage in or near the building

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 ➟ ❍ indoors ❍ outdoors ❑ fire, smoke ❑ flood, water leaks ❑ carpet cleaning
❑ new flooring, furniture, etc. *(please specify)* _____ ❑ construction ❑ renovation
❑ painting ❑ chemical spill, leak *(please specify)* _____ ❑ accidents ❑ stress

<u>On average</u>, how would you describe your present or most recent work environment?

Lighting	❑ too much glare	❑ satisfactory	❑ too dim	
Temperature	❑ too hot	❑ satisfactory	❑ too cold	❑ too variable
Air Movement	❑ too stuffy	❑ satisfactory	❑ too drafty	
Humidity	❑ too dry	❑ satisfactory	❑ too humid	
Odour	❑ none	❑ moderate	❑ strong	*Specify:* _____
Noise	❑ little	❑ moderate	❑ a lot	
Your Comfort Overall	❑ unsatisfactory	❑ somewhat satisfactory	❑ satisfactory	
Co-workers' Comfort Overall	❑ unsatisfactory	❑ somewhat satisfactory	❑ satisfactory	

SCHOOL (if applicable)

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 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	
Hydro 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

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)

❑ deodorizer strips	❑ furniture wax or polish	❑ odourous cleaning products
❑ 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

Do you think you are allergic to any seasonal pollens, animal danders, dust, mites, or moulds?

❑ No ❑ Yes *(please specify which)* _____

Have you ever had allergy tests? ❑ No ❑ Yes

If **YES**, please specify:

Age	Year	Type of Test	Results	Treatments (e.g. avoidance, shots, medications)	Improvement **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 (e.g. paints, perfumes, cosmetics, diesel exhaust, jet fuel, tar, etc.)?

❑ No ❑ Yes

'***Linked***' means that the symptom started or worsened within 48 hours after you were exposed to something, 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.

If **YES**, please specify chemical(s) and symptom(s):

Man-made Chemical	Symptoms Linked with Low Level Exposure	Presently Affected? **1** = a little **2** = somewhat **3** = a lot	In the Past **1** = a little **2** = somewhat **3** = a lot

How often do you use SCENTED personal products? *(please check)*

Scented Products	Soap	Lotion	Cosmetics	Hair permanent	Hair tint	Perfume/aftershave	Other(s) *(please specify)*
Never	❑	❑	❑	❑	❑	❑	❑ _____
Occasionally	❑	❑	❑	❑	❑	❑	❑ _____
Daily	❑	❑	❑	❑	❑	❑	❑ _____

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

❑ No ❑ Yes *(please specify)* _____

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: _____ Number of years: _____
- 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

Travel Illnesses

Have you ever experienced significant symptoms when travelling? ❑ No ❑ Yes

If **YES**, please specify:

Age	Year	Location	Symptoms

Blood Transfusion

Have you had blood transfusion(s)? ❑ No ❑ Yes ➟ *Year(s)* _____

Living Situation / Supports

Who lives at home with you? _____

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

Do you have spiritual beliefs / practices which help you cope?

❑ No ❑ Yes *(please comment)* _____

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

❑ No ❑ Yes *(please 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? _____

Stresses

Type of Stress	Ever had it?	When? *Please specify Year(s)*	Comments
Loss of someone close	❑ No ❑ Yes		
Illness in someone close	❑ No ❑ Yes		
Loss of job	❑ No ❑ Yes		
Change of job	❑ No ❑ Yes		
Change of workplace	❑ No ❑ Yes		
A 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		
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 & DRUG

1. **Who grocery shops for you?** _____
   Where? ❑ chain grocery store ❑ health food store ❑ market ❑ others *(please specify)* _____
2. **Who cooks for you?** _____
3. **Please indicate foods and beverages most typically consumed for each of the following meals and the times at which they are most typically eaten.**

Foods / Snacks	*Please Specify*	**Time**	**Beverage(s)**	*Please Specify*	**Time**
Breakfast			**Breakfast**		
Mid-Morning			Mid-Morning		
Lunch			**Lunch**		
Mid-Afternoon			Mid-Afternoon		
Dinner			**Dinner**		
Evening			Evening		

4. **How much of the following beverages do you consume regularly and have you linked any symptoms with drinking them?**
   ❑ **water** ➟ Number of 8 oz glasses per 24 hours _____ ❍ city ❍ 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) ➟ 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 _____ Any symptoms linked? _____
   ❑ **cola** ➟ Number of 12 oz drinks per 24 hours _____ ❍ regular ❍ diet Any symptoms linked? _____
   ❑ **other(s)** *(please specify)* _____ Any symptoms linked? _____
5. **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, salmon, shrimps, oysters, etc.): _____
6. **Do you use artificial sweetener?** ❑ No ❑ Yes ➟ On average, how many days per week? _____
   How many times per day? _____ Type(s) of sweetener: _____
7. **Please list foods / beverages that do not agree with you** (e.g. stuffy runny nose, heartburn, bloating, diarrhea, sleepiness, difficulty thinking or concentrating, etc.) **or cause 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?	Approximately how often do you eat / drink them?			
		Never	Occasionally	Daily	More than once a day

8. **Please list any foods / beverages that you crave or that help you to feel better and the time(s) the craving usually occurs:**

List foods / beverages that you **crave** or that 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

9. **Please list all PRESCRIPTION medications you currently take on a regular basis, including birth control pills and allergy injections: ***

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

** Use additional paper if necessary.*

10. **Please list all NON-PRESCRIPTION medications you currently take on a regular basis, including vitamins, minerals, herbs, remedies, etc.: ***

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

** Use additional paper if necessary.*

11. **Drug Adverse Reactions: Please list ANY medication / anesthetics / immunizations you have had to stop taking because of side effects or allergic reactions:**

Name of medication / immunization	Type of side effects or allergic reaction that caused you to stop it	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?_____

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Input from the Environmental Health Clinic Staff and Environmental Health Committee of the Ontario College of Family Physicians is gratefully acknowledged.