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Individual Health Exposure Assessment

Adapted from ACMT and ATSDR

Instructions: It will be helpful if you answer the questions as best you can. Please don't worry if you can't answer everything, but give as much detail as you can remember. All information you give about your health is strictly confidential.

PLEASE PRINT

Last Name:		First Name:		Middle Name:	Date:
Street Address:		City:		State:	Zip Code: Home/Cell Phone: ()
Date of Birth:	Age:	Marital Status (circle): Married Single Widow/Widower Divorced Partnered Separated		Gender:	Preferred language:
Name of Primary Care Provider:				Phone of Primary Care Provider: ()	
Email Address:				Preferred method of contact:	
May we leave a message: Yes/No If yes, where:				May we add this information to the confidential registry? Yes / No	

I, (print your name) _____, voluntarily consent to the EHP's exposure and health assessments, possible examination and/or testing for myself that will be completed by the authorized consultants of EHP. I acknowledge that no guarantees have been made to me as to the outcome of my assessment or examination.

I have been given a copy of EHP's privacy policy.

Signature: _____ Date: _____

Witness: _____ Date: _____

(Print Name)

(Signature)

Why are you here today? Do you have a current health concern? If so, please describe.

Have you seen other health care providers for this concern? If so when, and what tests were ordered?

What symptoms have you had? Circle all symptoms you have had in the past year. Write the date the symptom started. Write “N” if this is a “new” symptom. Write a “W” if you have had the symptom for more than one year, but it got “worse” over the past year. Write “O” for “ongoing” if you still have the symptom. Write “R” if the symptom has gone away for “resolved”. Add details to explain.

General Symptoms	Date Started	New or Worse	Ongoing or Resolved	Give Details of Your Symptoms
Weight loss				
Weight gain				
Weakness				
Fatigue				
Problems sleeping				
Dizziness				
Fever/chills				
Night sweats				
Other				
Skin Symptoms	Date Started	New or Worse	Ongoing or Resolved	Give Details of Your Symptoms
Skin rash				
Hives				
Blisters				
Skin irritation				
Itchiness or burning				
Skin cysts or growths				
Dry skin				
Other				
Eyes, Ears, Nose, Throat Symptoms	Date Started	New or Worse	Ongoing or Resolved	Give Details of Your Symptoms
Eye irritation				
Itchy eyes				
Burning eyes				
Vision problems/blurry/floaters				
ringing in ears				
Hearing loss				
Decrease sense of smell				
Frequent runny nose/colds				
Frequent sinus problems				
Sore throat/throat irritation				
Nose bleeds				
Bleeding gums				
Mouth irritation				
Dry mouth				
Other				

Name _____

Lung/Heart Symptoms	Date Started	New or Worse	Ongoing or Resolved	Give Details of Your Symptoms
Persistent/frequent cough				
Shortness of breath at rest				
Shortness of breath on exertion				
Wheezing				
Difficulty breathing				
Decreased exercise tolerance				
↑ heart rate				
↓ heart rate				
↑ blood pressure				
↓ blood pressure				
Heart palpitations				
Heart flutter				
Chest pain				
Other				
Stomach/Bladder/Bowel Symptoms	Date Started	New or Worse	Ongoing or Resolved	Give Details of Your Symptoms
Nausea				
Vomiting				
Abdominal pain				
Heartburn or indigestion				
Loss of appetite				
Frequent diarrhea				
Constipation				
Blood in stools				
Blood in urine				
Problems with urination				
Other				
Reproductive/Endocrine System	Date Started	New or Worse	Ongoing or Resolved	Give Details of Your Symptoms
Infertility/Loss of pregnancy				
Period/menstrual issues				
Menopause issues				
Children with birth defects				
Children with low birth weight				
Children with low APGAR scores				
Low testosterone				
Hair loss (not age related)				
↑ thirst				
↑ sweating				
Concerns about changes in sexual function				
Other				

Name _____

Nerves/Muscle Symptoms	Date Started	New or Worse	Ongoing or Resolved	Give Details of Your Symptoms
Headaches—details				
Frequent falls				
Balance difficulties				
Tremors (shakes or twitches)				
Numbness and/or tingling				
Confusion or memory loss				
Concentration difficulties				
Problems speaking				
Muscle aches or cramps				
Painful joints				
Swollen joints				
Other				
Blood System Symptoms	Date Started	New or Worse	Ongoing or Resolved	Give Details of Your Symptoms
Bruise easily				
Prolonged bleeding				
Other				
Psychological/Stress Symptoms	Date Started	New or Worse	Ongoing or Resolved	Give Details of Your Symptoms
Unusual moodiness				
Unusual irritability				
Anxiety				
Panic attacks				
Depression				
Anger				
Stress				
Other				

Comments/Additional Information

Name _____

CURRENT PRESCRIPTION and NON-PRESCRIPTION MEDICATIONS, HERBS & SUPPLEMENTS

Name of prescription and non-prescription medications, herbs, and supplements	Dose	Times per Day	When Started	Reason for taking	Does it help relieve symptoms?

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

Medication/Food/Other Agent	Side Effect/Reaction

PAST MEDICAL HISTORY:

Please check (✓) if you have ever been seen/treated by a healthcare provider for any of these conditions and give the date it started:

✓	Condition	Date	✓	Condition	Date
	Allergies/Hay Fever			Kidney disease	
	Bleeding problems			Liver disease	
	Cancer (type:)			Lung problems/TB	
	Depression			Metal poisoning	
	Diabetes			Multiple Chemical Sensitivity	
	Endocrine/Hormone(e.g., thyroid, low testosterone)			Neurological (e.g., tremor, stroke, blindness, seizures, coma, numbness, weakness, migraine)	
	Fibromyalgia			Psychological (e.g., depression, schizophrenia)	
	Hearing loss			Rash/skin issues	
	Heart disease			Valley Fever	
	High blood pressure			Other (Please specify)	

SURGICAL HISTORY List all surgical procedures and dates):

SOCIAL HISTORY: Check (✓) all that apply:

Smoking	Never/On occasion	How many years?	Packs per day?	If quit, when?	Do you want to quit?
Other Tobacco	Never/On occasion	What type?	How often?	If quit, when?	Do you want to quit?
Drinking	Never/On occasion	How many per day?	What type?	If quit, when?	Do you want to quit?

Name _____

FAMILY HISTORY: Check (√) if your parents or siblings have a history of:

Medical Problem	Check (√)	Parents or Siblings?	Medical Problem	Check (√)	Parents or Siblings?	Medical Problem	Check (√)	Parents or Siblings?
Allergies			Thyroid Disease			Lung Problems/TB		
Bleeding problems or Blood diseases			Heart Disease			Rashes/Skin Problems		
Cancer – Type of Cancer:			High Blood Pressure			Neurological (tremor/stroke/seizures)		
Chemical Sensitivity			Kidney Disease			Psychological (depression/schizophrenia)		
Diabetes			Liver Disease			Other		

WORK HISTORY: Jobs with any potential exposures – Start with Most Recent				
Date (from / to)	Company / Type of Industry	Job Title	Any Exposure to Vapors, Gas, Dusts or Fumes (specify)	Protective Equipment Advised If so what type worn

OTHER POSSIBLE EXPOSURE HISTORY: Check (√) if answer is “yes”

Do you wash work clothes at work?		Do you have a fireplace in your home? What type: _____ How often do you use it? _____	
Do you wash work clothes at home?		When was your house or apartment built?	
Do you shower at work?		Has your home been tested for radon? If yes what were the results?	
Do you shower at home?		Has your home had problems with mold?	
Are you regularly exposed to second hand smoke?		Has your home been remodeled in last 6 months?	
Do you have a carbon monoxide detector in your home?		Have you had to move because of health problems?	
If you have a carbon monoxide detector in your home, has it alarmed recently?		Do your symptoms get worse at work?	
Have you traveled out of the country during the past year? If yes, where?		Do your symptoms get better when you are away from your home?	
Have you recently acquired new furniture or carpeting or refinished furniture?		Other	