SOUTHWEST PENNSYLVANIA ENVIRONMENTAL HEALTH PROJECT
www.environmentalhealthproject.org

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Individual Health Exposure Assessment

Adapted from ACMT and ATSDR

As part of this project you will meet with a health care provider who will ask for some health information including a detailed occupational and environmental exposure history and a complete and accurate medical history. It will be helpful if you answer the questions as best you can before we meet. Please don't worry if you can't answer everything, but give as much detail as you can remember. You will talk about your answers at the interview. 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 Phone: ( )
Date of Birth:	Age:	Marital Status: M S W D	Sex: M / F	Social Security Number xxx - xx -
Name of Primary Care Provider:		Phone of Primary Care Provider: ( )		
Insurance Provider:		Group Name/ID		
Preferred method of contact:		May we leave a message: Yes/No If yes, where:		
Preferred language:				

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?

_____
_____
_____
_____

CURRENT PRESCRIPTION and NON-PRESCRIPTION MEDICATIONS, HERBS & SUPPLEMENTS

List all medications including prescription, non-prescription, herbal, vitamins and supplements you take. Use the back of the last page if you need more space.

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)	

Provide details if necessary for all checked boxes: _____

_____

_____

_____

_____

SURGICAL HISTORY List all surgical procedures and dates):

_____

_____

_____

Name_____

SOCIAL HISTORY: Check (√) all that apply:

Smoking	**Never**	**How many years?**	**Packs per day?**	**If quit, when?**	**Do you want to quit?**
Other Tobacco	**Never**	**What type?**	**How often?**	**If quit, when?**	**Do you want to quit?**
Drinking	**Never**	**How many per day?**	**What type?**	**If quit, when?**	**Do you want to quit?**
Recreational Drugs	**Never**	**What type?**	**How often?**	**If quit, when?**	**Do you want to quit?**

Education Completed: ___Grade school ___High school ___ Community College
___College ___Graduate school

Type of DIET: ___Regular ___Diabetic ___Vegetarian ___Vegan ___Organic ___Gluten Free ___Lactose Free

How often do you exercise: ___1-2 times/week ___3-4 times/week ___5 times or more/week ____Never

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

Allergies
Bleeding problems or blood diseases
Cancer (please specify type)
Chemical Sensitivity
Diabetes
Endocrine/Hormone for example thyroid, low testosterone
Heart disease
High blood presssure
Kidney disease
Liver disease
Lung problems / TB
Rashes/Skin issues
Neurological for example tremor, stroke, weakness, seizures, coma, numbness
Psychological for example depression, schizophrenia

Provide details for all checked boxes or other significant history:

_____
_____
_____

OCCUPATIONAL HISTORY:

Worksite History: Check (√) if you have ever worked in or around the following activities:

Chemical plant
Chemistry laboratory
Coke oven
Construction or demolition
Cotton, flax, or hemp mill
Electronics plant
Farm or agricultural
Firefighter
Flour or grain dust operation
Foundry
Hazardous waste industry (e.g., radiation)
Hospital or health care
Housekeeping/Office cleaning
Lumber mill
Metal production
Mine (underground/open pit)
Nuclear industry
Oil and gas industry
Paper mill
Pharmaceutical
Plastic production
Pottery or ceramics mill
Refinery
Rubber processing plant
Sand pit or quarry
Sand blasting
Service station
Shipyard or boat-building
Smelter
Truck driver
Waste industry (e.g., municipal garbage)

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

Work Questions

Are your work clothes laundered at home?_____ Do you shower at work?_____

Do your symptoms get worse at work or better on weekends or on vacations?_____

How many hours/day do you spend inside your house on the days you work? _____ On your days off? _____

CHEMICAL EXPOSURE HISTORY Check (√) if you are now exposed to or have ever worked with

Acids or caustics
Alcohols or Glycols
Arsenic
Artificial butter or other flavors
Cadmium
Carbon Disulfide
Carbon Tetrachloride
Chlorine or Hypochlorite
Chloroform
Chromates
Chromic acid mist
Cutting oils
DDT
Dioxin
Dust from coal
Dust from sandblasting
Dust from other
Epoxy resin
Ethylene Dibromide
Ethylene Oxide
Explosives or blasting
Extreme heat or cold
Fiberglass
Formaldehyde or Glutaraldehyde
Fumigants (including Vikane)
Glycol Ethers
Heptachlor
Hexachlorobenzene
Isocyanates (TDI, MDI)
Lead
Loud or continuous noise
Mercury
Methylene Chloride
Microwaves or lasers
Nickel
Paint or varnish
PCB's
Perfumes
Pesticides or herbicides
Petroleum ether
Phenol
Phosgene
Plastics
Radioactive materials
Roofing materials
Rubber
Silica, sand, or rock dust
Solvents/degreasers
Soots or tars
Spray painting
Styrene or Urethane
Talc
Toluene
Tri/ Perchloroethylene
Two-part glues or sealants
Vehicle or diesel exhaust
Vinyl Chloride
Welding fumes or gas
Xylene
Other:
_____

Name_____

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

Are you regularly exposed to second hand smoke?

Do you have a carbon monoxide detector in your home?
If yes, has it alarmed recently?

Do you have working fireplace? Type?_____
If yes how often do you use it?_____

Do you have gas appliances (stove, space heater, water heater?

Have you eaten from unglazed ceramic food ware?

Do you use unlined copper vessels?

Was your house or apartment built before 1970?

Are you aware of any old lead paint at home, at work, or in places where you spend a significant amount of time?

Has your home been tested for radon?
If yes, were the results high?

Has your home had any problems with mold?

Does your basement have a sump pump?

Does your home have asbestos or fiberglass?

Are pesticides or herbicides (bugs or weed killers or flea or tick sprays, collars, powders, or shampoos) used in your house or garden?

Do you or any other household member have a hobby or craft such as furniture refinishing, painting, hunting, shooting, or model building?

Do you work on your car?

Has your home been remodeled by you or a contractor in the last 6 months?

Have you recently acquired new furniture or carpet or refinished furniture?

Have you winterized your home recently?

Have you ever changed your residence because of health problems?

Do your symptoms get worse at work?

Do your symptoms get better when you are away from your home?

Have you been out of the country during the past year?
If yes, where_____

Do you get clothing dry cleaned?

Do you use cleaning products or disinfectants in your home?

REVIEW OF SYSTEMS: Circle all symptoms you have had in the past year. Write the date the symptom started. Write N if the symptom was new. Write W if you have had the symptom for more than one year, but it got worse over the past year. Write O if you still have the symptom. Write R if the symptom has gone away. Add details to explain.

Symptoms/Complaints	Date Started	New or Worse	Ongoing or Resolved	Details
General/Constitutional				
Weight loss				
Weight gain				
Weakness				
Fatigue				
Problems sleeping				
Dizziness				
Fever/chills				
Night sweats				
Other				
Dermatological				
Skin rash				
Hives				
Blisters				
Skin irritation				
Itchiness or burning				
Skin cysts or growths				
Dry skin				
Other				

Name_____

Eyes, Ears, Nose, Throat				
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				
Respiratory and Cardiac				
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				
Gastro-Intestinal/Urinary				
Nausea				
Vomiting				
Abdominal pain				
Heartburn or indigestion				
Loss of appetite				
Frequent diarrhea				
Constipation				
Blood in stools				
Blood in urine				
Problems with urination				
Other				

Name_____

Reproductive/Endocrine System				
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				
Other				
Neurological/Musculoskeletal				
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				
Bruise easily				
Prolonged bleeding				
Psychological				
Unusual moodiness				
Unusual irritability				
Anxiety				
Panic attacks				
Depression				
Anger				
Stress				
Other				

Comments

_____

_____

_____

Name_____