Taking An Exposure History

A mnemonic (CH\textsuperscript{2}OPD\textsuperscript{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.

- Community
- Home
- Hobby
- Occupation
- Personal
- Diet
- Drugs
## COMMUNITY

For each of the items listed below:

**Do you presently live nearby?**

<table>
<thead>
<tr>
<th>Item</th>
<th>No</th>
<th>Yes</th>
<th><strong>If you ever lived nearby, please write the years.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heavy traffic</td>
<td></td>
<td></td>
<td>highway</td>
</tr>
<tr>
<td>Vehicle idling area</td>
<td></td>
<td></td>
<td>auto</td>
</tr>
<tr>
<td>Dump site</td>
<td></td>
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<tr>
<td>Farm(s)</td>
<td></td>
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<tr>
<td>Industrial plant(s)</td>
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<tr>
<td>Polluted lake / stream</td>
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<tr>
<td>Nuclear power plant</td>
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<tr>
<td>Hydro towers</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other potential hazards</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**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

- Visible mould
  - No
  - Yes
    - slight
    - severe

- Crumbling pipe insulation
  - No
  - Yes (circle which one or both)

- 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:
- art work (e.g. painting, ceramics, stained glass, leather work, etc.)
  - Years:
- other non-occupational activities with exposure to toxic chemicals
  - Years:
OCCUPATION

1. Do you presently do volunteer work and/or work for pay?  □ Yes  □ No
   □ Volunteer work  ➔ Number of hours per week: __________________ Type: __________________
   □ Work for pay  ➔ Number of hours per week: __________________
   □ 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.

<table>
<thead>
<tr>
<th>Company Name &amp; Work Location</th>
<th>From Mth / Yr</th>
<th>To Mth / Yr</th>
<th>Job Title &amp; Description</th>
<th>Exposures*</th>
<th>Protective Measures / Equipment **</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>/</td>
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<td>2.</td>
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<tr>
<td>3.</td>
<td>/</td>
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<tr>
<td>4.</td>
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</tr>
</tbody>
</table>

   * 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

   On average, 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:

<table>
<thead>
<tr>
<th>Age</th>
<th>Year</th>
<th>Type of Test</th>
<th>Results</th>
<th>Treatments</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>(e.g. avoidance, shots, medications)</td>
<td>0 = worse 1 = none 2 = a little 3 = some 4 = a lot</td>
</tr>
</tbody>
</table>

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):

<table>
<thead>
<tr>
<th>Man-made Chemical</th>
<th>Symptoms Linked with Low Level Exposure</th>
<th>Presently Affected?</th>
<th>In the Past</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1 = a little 2 = somewhat 3 = a lot</td>
<td>1 = a little 2 = somewhat 3 = a lot</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Scented Products</th>
<th>Soap</th>
<th>Lotion</th>
<th>Cosmetics</th>
<th>Hair permanent</th>
<th>Hair tint</th>
<th>Perfume/aftershave</th>
<th>Other(s) (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>☐</td>
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<td>☐</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td>Occasionally</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Daily</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Age</th>
<th>Year</th>
<th>Location</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Type of Stress</th>
<th>Ever had it?</th>
<th>When? Please specify Year(s)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of someone close</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illness in someone close</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of job</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change of job</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change of workplace</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A move</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage</td>
<td>☐ No ☐ Yes</td>
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<tr>
<td>Separation</td>
<td>☐ No ☐ Yes</td>
<td></td>
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<tr>
<td>Divorce</td>
<td>☐ No ☐ Yes</td>
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<tr>
<td>Pregnancy</td>
<td>☐ No ☐ Yes</td>
<td></td>
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<tr>
<td>Alcohol / drug addiction</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol / drug addiction in someone close</td>
<td>☐ No ☐ Yes</td>
<td></td>
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</tr>
<tr>
<td>Physical abuse</td>
<td>☐ No ☐ Yes</td>
<td></td>
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<tr>
<td>Emotional abuse (being put down, called names)</td>
<td>☐ No ☐ Yes</td>
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<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
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<tr>
<td>Other (please specify)</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Foods / Snacks</th>
<th>Please Specify</th>
<th>Time</th>
<th>Beverage(s)</th>
<th>Please Specify</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
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<td>Breakfast</td>
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<tr>
<td>Mid-Morning</td>
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<td>Mid-Morning</td>
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<tr>
<td>Lunch</td>
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<tr>
<td>Mid-Afternoon</td>
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<td>Mid-Afternoon</td>
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<tr>
<td>Dinner</td>
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<td>Dinner</td>
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<tr>
<td>Evening</td>
<td></td>
<td></td>
<td>Evening</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.):

<table>
<thead>
<tr>
<th>List foods / beverages that are a problem</th>
<th>What problem(s) do they give you?</th>
<th>Approximately how often do you eat / drink them?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Never</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>List foods / beverages that you crave or that help you to feel better</th>
<th>Time(s) of craving</th>
<th>What problem(s), if any, do they give you?</th>
<th>Approximately how often do you eat / drink them?</th>
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<tbody>
<tr>
<td></td>
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<td>Never</td>
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</table>
9. Please list all PRESCRIPTION medications you currently take on a regular basis, including birth control pills and allergy injections: *

<table>
<thead>
<tr>
<th>Name of prescription medication</th>
<th>Dose (e.g. mg, ml, IU)</th>
<th>How often do you take it?</th>
<th>How long have you taken it?</th>
<th>If you have side effects, please specify</th>
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* 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.: *

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

* 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:

<table>
<thead>
<tr>
<th>Name of medication / immunization</th>
<th>Type of side effects or allergic reaction that caused you to stop it</th>
<th>Age</th>
<th>Year</th>
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</thead>
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</table>

12. Have you EVER had an emergency injection of adrenaline (epinephrine) for a reaction to any medication, food, insect sting, or other substance?

- [ ] No
- [X] Yes ➔ What year(s)? ____________________________
  To what? _________________________________________


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