

Taking An Exposure History

A mnemonic (CH²OPD²) 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	<input type="checkbox"/> No	<input type="checkbox"/> Yes (please specify)	<input type="radio"/> highway	<input type="radio"/> busy street	_____
Vehicle idling area	<input type="checkbox"/> No	<input type="checkbox"/> Yes (please specify)	<input type="radio"/> auto	<input type="radio"/> bus / truck	_____
Dump site	<input type="checkbox"/> No	<input type="checkbox"/> Yes (please specify type)			_____
Farm(s)	<input type="checkbox"/> No	<input type="checkbox"/> Yes (please specify type)			_____
Industrial plant(s)	<input type="checkbox"/> No	<input type="checkbox"/> Yes (please specify type)			_____
Polluted lake / stream	<input type="checkbox"/> No	<input type="checkbox"/> Yes (please specify type)			_____
Nuclear power plant	<input type="checkbox"/> No	<input type="checkbox"/> Yes			_____
Hydro towers	<input type="checkbox"/> No	<input type="checkbox"/> Yes			_____
Other potential hazards	<input type="checkbox"/> No	<input type="checkbox"/> 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 mold 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,	<input type="checkbox"/> Volunteer work → Number of hours per week: _____ Type: _____
	<input type="checkbox"/> Work for pay → Number of hours per week: _____
If no,	<input type="checkbox"/> Unable to work for pay due to health problems → Date stopped work: _____ Reason(s): _____
	<input type="checkbox"/> On disability benefits → Type: _____ OR Disability claim → <input type="checkbox"/> unresolved <input type="checkbox"/> 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

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:

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Occasionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

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? <i>Please specify Year(s)</i>	Comments
Loss of someone close	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Illness in someone close	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Loss of job	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Change of job	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Change of workplace	<input type="checkbox"/> No <input type="checkbox"/> Yes		
A move	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Marriage	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Separation	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Divorce	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Alcohol / drug addiction	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Alcohol / drug addiction in someone close	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Physical abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Emotional abuse (being put down, called names)	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Sexual abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Other (please specify)	<input type="checkbox"/> No <input type="checkbox"/> 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

Exposure History References

1. American Academy of Environmental Medicine. **Allergy Database and Health History**. AAEM, Inc., Wichita, Kansas, 1992.
2. Anthony Honor, Birtwistle Sybil, Eaton Keith, Maberly Jonathan. **Environmental Medicine in Clinical Practice**. BSAENM Publications (PO Box 28, Totton, Southampton, SO40 27A, Tel: 01 703 81 2124) 1997.
3. Bucsela J, Ed. Agency for Toxic Substances and Disease Registry. **Case Studies in Environmental Medicine: Taking an Exposure History**. US Department of Health and Human Services, October 1992.
4. Marshall LM, Mckeown-Eyssen G, Sokoloff E, Jazmaji V. **University of Toronto Health Survey**. University of Toronto, Department of Public Health Sciences, 1995.
5. Miller CS, Prihoda TJ. **The Environmental Exposure and Sensitivity Inventory (EESI): A standardized approach for measuring chemical intolerances for research and clinical applications**, *Toxicology and Industrial Health* 15:370–385, 1999.
6. Miller CS, Prihoda TJ. **A Controlled Comparison of Symptoms and Chemical Intolerances reported by Gulf War Veterans, Implant Recipients and Persons with Multiple Chemical Sensitivity**, *Toxicology and Industrial Health* 15:386–397, 1999.
7. Quinlan P, Macher JA, Alevantis LE, Cone JE. **Protocol for the Comprehensive Evaluation of Building-Associated Illness** in *Occupational Medicine: State of the Art Reviews*, Vol. 4, No. 4, pp. 771–797, October – December 1989. Philadelphia, Hanley & Belfus, Inc.
8. Raw GJ. **Office Environment Survey**. Construction Research Communications Ltd. Building Research Establishment, Garston, Watford, WE27JR, 1995.
9. Small Bruce M. **Recommendations for Action on Pollution and Education in Toronto: A Report prepared for the Pollution and Education Review Group of the Board of Education, the City of Toronto**, May 1985.
10. Steel R, Belk S, Eds. **Taking an Environmental History** in Handbook of Pediatric Environmental Health, American Academy of Pediatrics, 25–31, 1999.

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