

# Taking An Exposure History

A mnemonic (CH<sup>2</sup>OPD<sup>2</sup>) 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 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,	<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 <b>crave</b> 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? \_\_\_\_\_

## *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.

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