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
Hobby
O ccupation
P ersonal
D iet
D rugs

Please answer all questions.
Exposure History

COMMUNITY

For each of the items listed below:

Do you presently live nearby (within 300 m- about 3 mid-sized city blocks)

- Heavy traffic
  - No
  - Yes (please specify)
    - highway
    - busy street

- Vehicle idling area
  - No
  - Yes (please specify)
    - auto
    - bus / truck

- Dump site(s)
  - No
  - Yes (please specify types)

Areas sprayed with pesticides:
  - No
  - Yes (please specify type)
    - e.g. Farm(s), Orchard(s), Golf Course

- Industrial plant(s)
  - No
  - Yes (please specify types)

- Polluted lake / stream
  - No
  - Yes (please specify)

- Nuclear power plant
  - No
  - Yes

- Electricity towers
  - No
  - Yes

- Airport
  - No
  - Yes (please name)

- Cellphone towers
  - No
  - Yes
    - How many?

- Other potential hazards
  - No
  - Yes (please specify type)

- Commute
  - No
  - Yes
    - How long both ways?
    - __________ min
    - Type of transportation: ______________

Do you protect yourself from excess sun exposure?
  - No
  - Yes
    - rarely
    - occasionally
    - often/always
    - using clothing
    - sun block

Use tanning bed?
  - No
  - Yes
    - (How often?) ______________

Use tanning solutions?
  - No
  - Yes
    - (How often?) ______________

HOME & HOBBY

How long have you lived in your present residence? ________________

How old is it? ________________

Is your residence:
  - On a First Nations reserve (please name) ________________
  - house (detached) ________________
  - house (semi-detached) ________________
  - mobile home ________________
  - apartment ________________
  - basement ________________
  - # of floors ___ your floor __________
  - On what floor is your bedroom? __________
  - Age of your mattress ________________

Do you use dust mite-proof:
  - Pillow cover(s)? __ No
  - Mattress cover(s)? __ No

Ownership?
  - owner occupied ________________
  - rental ________________
  - co-op ________________
  - public housing ________________

How is your home heated?
  - forced air ________________
  - hot water radiators ________________
  - space heater ________________
  - baseboard heaters ________________
  - other ________________

What type of fuel is used for heating?
  - natural gas ________________
  - oil ________________
  - wood ________________
  - electricity ________________
  - propane ________________

Has your home or apartment building been tested for radon?
  - No
  - Yes
    - When? ________________

Have any renovations been done since you’ve moved in?
  - No
  - Yes
    - When? ________________

Do you use:
  - central vacuum? ________________
  - HEPA filter vacuum? ________________
  - other vacuum? (please specify) ________________

What is your water source for bathing?
  - city ________________
  - well ________________
  - other (please specify) ________________

What product(s) do you usually use in your home? (please specify brands)

- bathroom cleanser ________________
  - floor / wall cleanser ________________
- laundry detergent ________________
  - liquid fabric softener ________________
  - window cleaner ________________
  - dryer sheets ________________

If you have ever lived nearby, please write the number of years in the appropriate age group(s).

<table>
<thead>
<tr>
<th>Age</th>
<th>0-5</th>
<th>6-17</th>
<th>18-40</th>
<th>41-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
For each of the items listed below, do you presently have/use:

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes/No</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basement cracks or dirt floor</td>
<td>No</td>
<td>(circle which one or both)</td>
</tr>
<tr>
<td>Damp, musty basement or crawl space</td>
<td>No</td>
<td>(circle which one or both)</td>
</tr>
<tr>
<td>Wet windows or outside closet walls (condensation)</td>
<td>No</td>
<td>O slight O severe Where?</td>
</tr>
<tr>
<td>Water leaks or water damage</td>
<td>No</td>
<td>O slight O severe Where?</td>
</tr>
<tr>
<td>Visible mould</td>
<td>No</td>
<td>O slight O severe Where?</td>
</tr>
<tr>
<td>Crumbling pipe insulation</td>
<td>No</td>
<td>O slight O severe</td>
</tr>
<tr>
<td>Flaking paint</td>
<td>No</td>
<td>O slight O severe</td>
</tr>
<tr>
<td>Stagnant stuffy air</td>
<td>No</td>
<td>O slight O severe</td>
</tr>
<tr>
<td>Gas or propane stove</td>
<td>No</td>
<td>(circle which one or both)</td>
</tr>
<tr>
<td>Other gas appliances</td>
<td>No</td>
<td>(please specify)</td>
</tr>
<tr>
<td>Microwave</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Wood stove or fireplace</td>
<td>No</td>
<td>(circle which one or both)</td>
</tr>
<tr>
<td>Air conditioning</td>
<td>No</td>
<td>O central O individual rooms</td>
</tr>
<tr>
<td>Electrostatic air cleaner</td>
<td>No</td>
<td>O slight</td>
</tr>
<tr>
<td>Other air cleaner(s)</td>
<td>No</td>
<td>(please specify)</td>
</tr>
<tr>
<td>Deodorizer</td>
<td>No</td>
<td>(please specify)</td>
</tr>
<tr>
<td>Carbon Monoxide Detector</td>
<td>No</td>
<td>How many?</td>
</tr>
<tr>
<td>Smoke detector</td>
<td>No</td>
<td>How many?</td>
</tr>
<tr>
<td>Smoking at home</td>
<td>No</td>
<td>Who smoked?</td>
</tr>
<tr>
<td>Smoking in car</td>
<td>No</td>
<td>Who smoked?</td>
</tr>
<tr>
<td>WiFi / Router</td>
<td>No</td>
<td>When did you install?</td>
</tr>
<tr>
<td>Smart meter</td>
<td>No</td>
<td>Where?</td>
</tr>
<tr>
<td>Carpets</td>
<td>No</td>
<td>Where? How old?</td>
</tr>
<tr>
<td>Vinyl linoleum</td>
<td>No</td>
<td>Where? How old?</td>
</tr>
<tr>
<td>Pesticides</td>
<td>No</td>
<td>Where?</td>
</tr>
<tr>
<td>Pets</td>
<td>No</td>
<td>Yes (please specify kind &amp; number)</td>
</tr>
<tr>
<td>Pets sleep in your bedroom</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Indoor plants</td>
<td>No</td>
<td>How many?</td>
</tr>
<tr>
<td>Garage</td>
<td>No</td>
<td>O attached O underground</td>
</tr>
<tr>
<td>Furniture stripping / refinishing</td>
<td>No</td>
<td>(please specify type)</td>
</tr>
<tr>
<td>Home renovating (hobby)</td>
<td>No</td>
<td>(please specify type)</td>
</tr>
<tr>
<td>Art work</td>
<td>No</td>
<td>(please specify type)</td>
</tr>
<tr>
<td>Other non-occupational activities with exposure to toxic chemicals (hobbies)</td>
<td>No</td>
<td>(please specify type)</td>
</tr>
</tbody>
</table>

What hobbies do members of your household have?

What hobbies do members of your household have?

Do you participate in sports? No Yes (please specify what & how often)
OCCUPATION
Do you presently do volunteer work and/or work for pay?

☐ Yes  ☐ No

If yes,  
☐ Volunteer work  \(\rightarrow\) Number of hours per week: \__________\  Type: \__________\  
☐ Work for pay  \(\rightarrow\) Number of hours per week:

If no,  
☐ Unable to work for pay due to health problems  \(\rightarrow\) Date stopped work: 
Reason(s): \__________\ 
☐ On disability benefits:  \(\rightarrow\) ODSP  ☐ CPP  ☐ WSIB  ☐ Other (please specify) \__________\  OR  
Disability claim  ☐ unresolved  ☐ permanently denied

Starting with your present or most recent job, please list all of the paying jobs you have ever had (including summer jobs). Please use additional paper if necessary.

* Please list the significant chemicals, dusts, fibres, fumes, radiation, biologic agents (e.g. bacteria, moulds, viruses), electromagnetic fields 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.).

<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>
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<td>2.</td>
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<td>5.</td>
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<td>6.</td>
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<td>7.</td>
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</tbody>
</table>

Have you ever served in the military?  ☐ No  ☐ Yes  \(\rightarrow\) when?  \__________\  where?  \__________\  

The following questions are about your present or most recent work environment:

Age of Building: \__________\  Number of Floors: \__________\  Approximate number of occupants: \__________\  
Neighbourhood:  \(\rightarrow\) rural  \(\rightarrow\) commercial  \(\rightarrow\) industrial  
Smoking allowed on property?  ☐ No  ☐ Yes

Which of the following are / were on the same floor as your work station in your present or most recent work?

☐ banks of computers  ☐ WiFi  ☐ unvented copy machines  ☐ partitions or room dividers  
☐ central air conditioning  ☐ windows that open  ☐ carpets  \(\rightarrow\) How old?  \__________\  ☐ co-workers wearing perfume  
☐ number of co-workers complaining of feeling ill at work  \__________\  Please specify symptoms  \__________\ 

Can / could you smell odours from the following in your present or most recent work environment?

☐ laboratory  ☐ cafeteria  ☐ manufacturing area  ☐ idling vehicles  ☐ parking garage

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  \(\rightarrow\) O indoors  O outdoors  ☐ fire, smoke  ☐ flood, water leaks  ☐ carpet cleaning  
☐ new flooring, furniture, etc. (please specify)  \__________\  ☐ painting  ☐ deodorizer use  
☐ construction or renovation or ☐ chemical spill, leak (please specify)  \__________\  
☐ stress (please specify)  \__________\  

Ontario College of Family Physicians  •  Environmental Health Clinic  Compiled by Marshall, Bray, Molot, Basted, Kerr  January 2015
SCHOOL
(Complete this form only if you are going to school
OR if your child is the patient and is going to school)
☐ not applicable to me

Personal or Child’s level of education (Please check one)
No formal schooling ☐ Some primary ☐ Completed primary ☐ Some secondary or high school ☐ Completed secondary or high school ☐ Diploma/Apprenticeship ☐ Some University ☐ Completed University degree (please specify)_________________

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 (within 300 m or about 3 city blocks) of 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

Electric towers ☐ No ☐ Yes

Cell 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
☐ laptops ☐ WiFi hubs When installed? __________

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)
☐ deodorizers ☐ furniture wax or polish ☐ odourous cleaning products
☐ deodorant sprays ☐ 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**
Have you ever had allergy tests or treatments? (seasonal pollens, animal danders, dust, mites, or moulds)?

- [ ] No
- [ ] Yes  *If YES, please specify below:*

<table>
<thead>
<tr>
<th>Approx. Age</th>
<th>Approx. Year</th>
<th>Type of Test</th>
<th>Positive Results <em>(please specify)</em></th>
<th>Treatments <em>(e.g. avoidance, shots, medications)</em></th>
<th>Improvement after 1 year</th>
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<tbody>
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</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?

*‘Linked’ means that the symptom started or worsened within 48 hours after you were exposed to something, and/or the symptom improved or disappeared after you were no longer exposed to it.*

- [ ] No  *If YES, please specify chemical(s) and symptom(s) below (please use additional paper, if necessary).*

<table>
<thead>
<tr>
<th>Man-made Chemical</th>
<th>Symptoms Linked with Low Level Exposure</th>
<th>Presently Affected?</th>
<th>With avoidance, how long for symptoms to disappear?</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1 = a little 2 = somewhat 3 = a lot</td>
<td>1 = mins 2 = hours 3 = days</td>
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</tbody>
</table>

**Do you use SCENTED personal or hair products?** *(please check)*

- [ ] No
- [ ] Yes  *If YES, please specify below:*

<table>
<thead>
<tr>
<th>Scented Products</th>
<th>Soap</th>
<th>Lotion</th>
<th>Cosmetics</th>
<th>Perfume/ Cologne/ Aftershave</th>
<th>Hair permanent</th>
<th>Hair colour</th>
<th>Hair Spray</th>
<th>Other(s) <em>(please specify)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrequently</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Daily</td>
<td></td>
<td></td>
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</tbody>
</table>

**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: _____ # of years: _____ Interested in a smoking cessation program?*  
- [ ] No
- [ ] Yes

*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:  

**Have you ever experimented with “recreational drugs”?**  
- [ ] No
- [ ] Yes →  
  - What drugs? ________________
  - What age/s? ________________

**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 a bridge, denture or partial plate?  
- [ ] No
- [ ] Yes  → Number of Year(s): ______

Do you have other artificial materials in your body? (e.g. pins, screws, plates, meshes, valves, implants, etc.)  
- [ ] No
- [ ] Yes *(please specify)* ________________________________
**Electromagnetic Fields ``Screen Time``**

<table>
<thead>
<tr>
<th>How often do you use: (please circle)</th>
<th>Infrequently</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>never/rarely</td>
<td>&lt; once/week</td>
</tr>
<tr>
<td>Cell phone</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Cordless phone</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Laptop computer</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Desktop computer/video display unit</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Remote headset</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Wireless Devices (i.e. TV, mouse, keyboard)</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Blood Transfusion, Immunization Reaction, Travel Illness**

Have you had blood transfusion(s)? ☐ No ☐ Yes → Year(s) _________ Circumstances? ___________________

Have you had abnormal reactions to immunizations? ☐ No ☐ Yes → Type________ Year(s)________

Have you ever experienced significant symptoms when travelling? ☐ No ☐ Yes → Please specify year, location, symptoms: ________________

**Living Situation / Supports / Stresses**

Who lives at home with you? ________________________________________________________________

Are you: ☐ single ☐ married / cohabitating ☐ separated ☐ divorced ☐ widowed

Do you have inner or spiritual beliefs or mindfulness activities which help you cope? 
☐ No ☐ Yes (please specify)

Are you part of a social or religious community which helps you cope? 
☐ No ☐ Yes (please specify and 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? ____________________________________________________________

<table>
<thead>
<tr>
<th>Type of Stress</th>
<th>Ever had it?</th>
<th>When?</th>
<th>Comments (e.g. who or circumstances involved)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of someone close</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe illness- someone close</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty (family income less than $20, 000 /yr)</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 or workplace</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household move</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separation</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorce</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>In jail</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical abuse</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional abuse (being put down, called names)</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>☐ No ☐ Yes</td>
<td></td>
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</tr>
</tbody>
</table>
**Exposure History**

**DIET**

Who grocery shops? __________________________________________ Who cooks? __________________________________________

Please indicate the top 3 foods, snacks, beverages and combinations you typically consume in a week (e.g. wheat cereal, sugar and milk):

<table>
<thead>
<tr>
<th>Foods / Snacks /Combinations</th>
<th>Please Specify</th>
<th>Beverages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td>1.</td>
<td>2.</td>
</tr>
<tr>
<td>Mid-Morning</td>
<td>1.</td>
<td>2.</td>
</tr>
<tr>
<td>Lunch</td>
<td>1.</td>
<td>2.</td>
</tr>
<tr>
<td>Mid-Afternoon</td>
<td>1.</td>
<td>2.</td>
</tr>
<tr>
<td>Dinner</td>
<td>1.</td>
<td>2.</td>
</tr>
<tr>
<td>Evening</td>
<td>1.</td>
<td>2.</td>
</tr>
</tbody>
</table>

- **Do you eat organic food?** □ No □ Yes → circle how often: Rarely/About once/wk/2 times/wk/Daily/Several x daily
- **Do you eat foods with food colouring?** □ No □ Yes → circle how often: Rarely/About once/wk/2 times/wk/Daily/Several x daily
- **Do you use artificial sweetener?** □ No □ Yes → circle how often: Few times/wk/2 times/wk/Daily/Several x daily
- **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, shark, swordfish, local fish, salmon, tilapia, shrimps, oysters, other: Wild Farm
- **Do you eat hunted game meat?** □ No □ Yes → Type On average, how many days per week? How many times per day?

How much of the following beverages do you consume regularly and have you linked any symptoms?

- water → Number of 8 oz glasses per 24 hours 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, gin, vodka) → 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 Please specify type Any symptoms linked?
- sodas → Number of drinks per 24 hours Please specify Any symptoms linked
- cola → Number of 12 oz drinks per 24 hours □ regular □ diet Any symptoms linked?
- energy drinks → Number of 12 oz drinks per 24 hours Amount of caffeine/drink Any symptoms linked?
- other(s) (please specify) Any symptoms linked?

Please list foods / beverages that do not agree with you (e.g. stuffy runny nose, headache, heartburn, bloating, diarrhea, sleepiness, difficulty thinking or concentrating, etc.) or trigger allergic reactions (e.g. hives, rash, 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>With avoidance, how long for symptoms to disappear?</th>
<th>Approximately how often do you eat / drink them?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mins</td>
<td>Hrs</td>
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</tbody>
</table>

Please list any foods / beverages that you crave or help you to feel better:

<table>
<thead>
<tr>
<th>List foods / beverages that you crave or 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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Never</td>
</tr>
</tbody>
</table>

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Ontario College of Family Physicians • Environmental Health Clinic  Compiled by Marshall, Bray, Molot, Basted, Kerr  January 2015
Please list all PRESCRIPTION medications you currently take on a regular basis, including birth control pills and allergy injections *(please use additional paper if necessary)*:

<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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</thead>
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</tbody>
</table>

Have you ever taken steroids?  ☐ No  ☐ Yes →  ☐ Nose Spray  ☐ Inhaler  ☐ By Mouth

Please specify when _____________________________

Have you ever taken antibiotics for more than one month?  ☐ No  ☐ Yes →

List condition(s) _____________________________ When _____________________________ Name of antibiotic(s) _____________________________

Have you ever used antifungals?  ☐ No  ☐ Yes →  ☐ By Mouth  ☐ Cream/Gel  ☐ Shampoo

List condition(s) _____________________________ When _____________________________ Name of antifungal(s) _____________________________

Please list all NON-PRESCRIPTION medications you currently take on a regular basis, including vitamins, minerals, herbs, remedies, etc. *(please use additional paper if necessary)*:

<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>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Drug Adverse Reactions: Please list ANY medication / anaesthetic / immunization you have had to stop taking because of side effects or allergic reactions:

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

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? ________________________________________________________________

Do you have an EpiPen or Twinject?  ☐ No  ☐ Yes →  *When was it prescribed?* ________