



**ENVIRONMENTAL EXPOSURE QUESTIONNAIRE**

If you have been exposed to any of these in the LAST 12 MONTHS please check:

- (Y) Yes
- (N) No
- (?) Unknown
- (P) for exposure greater than 12 months ago

**COMMUNITY**

Do you have regular exposure to any of the following:	Y	N	?	P	Notes
Automobile exhaust					
Farm/Industrial/Power plant or lines					
Landfill/Dump					
Hydro tower					
Other:					

**HOME AND/OR WORK ENVIRONMENT**

Please circle the appropriate selection:

Do you live in a: house    apartment building    condominium

Do you work in a: house    office building    factory

Bathing/showering water source: public works    well    filtered

Do you have regular exposure to any of the following:	Y	N	?	P	Notes
Forced air heat					
Renovations (new carpets; add ons; etc...)					
Basement cracks or dirt floor					
Damp basement or crawl space					
Wet windows or outside closet walls					
Visible mold					
Old or cracking ceiling tiles					
Old or cracking vinyl linoleum flooring					
Crumbling pipe insulation					
Crumbling wall or ceiling insulation					
Old or cracking paint					
Carpets or rugs					
Stagnant or stuffy air					
Gas or propane stove					
Other gas appliance (water heater, furnace)					
Regular contact with cigarette smoke					
Other:					

HOBBY AND WORK ACTIVITIES

Do you have regular exposure to any of the following:	Y	N	?	P	Notes
Pesticides or herbicides					
Harsh chemicals (varnish, glue, acid...)					
Welding or soldering					
Metals (Lead, Mercury etc)					
Paints					
Photo developing/dark room					
Airplane travel					
Cleaning chemicals					

PERSONAL – MEAL PLAN

Please circle the appropriate selection:

Drinking/cooking water source: well public works bottled filtered

Do you regularly eat:	Y	N	?	P	Notes
Fish (fresh, frozen, canned etc.)					
Artificial sweeteners (please circle): NutraSweet, Equal, Aspartame, Splenda					
Alcohol					
Animal products					
How often?					
What percentage of your animal product is organic?					
Do you wash your produce?					
• What percentage of your produce is organic?					
Deep fried foods					
Sodas, juices, drinks containing High Fructose Corn Syrup?					
• How many per day?					
Do you have:	Y	N	?	P	Notes
Allergies					
Sensitivity to smells (gas, perfume, paint etc...)					
Artificial material in the body (implants, pins, joints etc...)					
Have you ever:					
Used tobacco					
Experimented with recreational drugs					
Lead a high stress lifestyle					
Had an illness during foreign travel					
Had an illness while camping or hiking					
Had food poisoning					

DENTAL

Do you have regular exposure to any of the following:	Y	N	?	P	Notes
Do you currently have amalgam fillings or caps?					
Have you removed or lost dental fillings or caps?					
Did you have fillings as child?					

