

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

Please answer all questions.

OCCUPATION

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 → <input type="checkbox"/> ODSP <input type="checkbox"/> CPP <input type="checkbox"/> WSIB OR Disability claim <input type="checkbox"/> unresolved <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> 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.).

| Company Name & Work Location | From Mth / Yr | To Mth / Yr | Job Title & Description | Exposures* | Protective Measures / Equipment ** |
|------------------------------|---------------|-------------|-------------------------|------------|------------------------------------|
| 1. | / | / | | | |
| 2. | / | / | | | |
| 3. | / | / | | | |
| 4. | / | / | | | |
| 5. | / | / | | | |
| 6. | / | / | | | |
| 7. | / | / | | | |

Have you ever served in the military? No Yes → 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: rural commercial 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 → 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 → indoors 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) _____

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 | <input type="checkbox"/> No | <input type="checkbox"/> Yes (please specify) | <input type="checkbox"/> highway | <input type="checkbox"/> busy street |
| Vehicle idling area | <input type="checkbox"/> No | <input type="checkbox"/> Yes (please specify) | <input type="checkbox"/> auto | <input type="checkbox"/> 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 | | |
| Electric towers | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Cell Towers | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | |
| Other potential hazards | <input type="checkbox"/> No | <input type="checkbox"/> Yes (please specify type) | _____ | |

Which of the following does your or your child's school have? (Please check all that apply)

- | | | | | |
|---|---|---|-----------------------------|------------------------------|
| <input type="checkbox"/> carpeted classrooms | <input type="checkbox"/> central air conditioning | <input type="checkbox"/> art room – exhaust hood? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> unvented copy machine(s) | <input type="checkbox"/> windows that open | <input type="checkbox"/> laboratory – exhaust hood? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> flaking paints | <input type="checkbox"/> mouldy smell | <input type="checkbox"/> workshop – exhaust hood? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> laptops | <input type="checkbox"/> 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)

- | | | | |
|---|---|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> carpet cleaning | <input type="checkbox"/> construction | <input type="checkbox"/> renovation | <input type="checkbox"/> painting |
| <input type="checkbox"/> new flooring or furniture (please specify) _____ | <input type="checkbox"/> flood, water leaks | <input type="checkbox"/> roof tarring | |
| <input type="checkbox"/> use of pesticides / herbicides | → <input type="checkbox"/> indoors | <input type="checkbox"/> outdoors | |

Are the following products used in your or your child's school during the school year?

(Please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> deodorizers | <input type="checkbox"/> furniture wax or polish | <input type="checkbox"/> odourous cleaning products |
| <input type="checkbox"/> deodorant sprays | <input type="checkbox"/> floor wax | <input type="checkbox"/> scented washroom soap |
| <input type="checkbox"/> spray paints | <input type="checkbox"/> permanent markers | <input type="checkbox"/> 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:*

| Approx. Age | Approx. Year | Type of Test | Positive Results (please specify) | Treatments (e.g. avoidance, shots, medications) | Improvement after 1 year 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?

'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.

'Exposure' means being near, touching, smelling, breathing in, eating, drinking, swallowing or injecting something.

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

| Man-made Chemical | Symptoms Linked with Low Level Exposure | Presently Affected? 1 = a little 2 = somewhat 3 = a lot | With avoidance, how long for symptoms to disappear? 1 = mins 2 = hours 3 = days |
|-------------------|---|--|--|
| | | | |
| | | | |
| | | | |
| | | | |

Do you use **SCENTED** personal or hair products? (please check) No Yes *If YES, please specify below:*

| Scented Products | Soap | Lotion | Cosmetics | Perfume/ Cologne/ Aftershave | Hair permanent | Hair colour | Hair Spray | Other(s) (please specify) |
|------------------|--------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------------|
| Infrequently | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> _____ |

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: Year _____

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) _____

Do you have body art? No Yes → Tattoos → Number: _____ Piercings → Number: _____

Electromagnetic Fields ``Screen Time``

| How often do you use: (please circle) | Infrequently | | Daily | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | never/rarely | < once/week | <30 min | 1-3 hrs. | 4-7 hrs. | 8 hrs or more |
| Cell phone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cordless phone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Laptop computer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Desktop computer/video display unit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Remote headset | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Wireless Devices (i.e. TV, mouse, keyboard) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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? _____

| Type of Stress | Ever had it? | When? Specify year(s) | Comments (e.g. who or circumstances involved) |
|---|--|--------------------------|---|
| Loss of someone close | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Severe illness- someone close | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Poverty (family income less than \$20, 000 /yr) | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Loss of job | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Change of job or workplace | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Household 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 | | |
| In jail | <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

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):

| Foods / Snacks /Combinations | Please Specify | | | Beverages |
|------------------------------|----------------|----|----|-----------|
| Breakfast | 1. | 2. | 3. | |
| Mid-Morning | 1. | 2. | 3. | |
| Lunch | 1. | 2. | 3. | |
| Mid-Afternoon | 1. | 2. | 3. | |
| Dinner | 1. | 2. | 3. | |
| Evening | 1. | 2. | 3. | |

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 → On average, how many days per week? _____ How many times per day? _____

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 _____ Farmed _____

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 _____ city well water 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, 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, rashes, shortness of breath, wheezing, anaphylaxis, etc.):

| List foods / beverages that are a problem | What problem(s) do they give you? | With avoidance, how long for symptoms to disappear? | | | Approximately how often do you eat / drink them? | | | |
|---|-----------------------------------|---|-----|------|--|--------------|-------|--------------|
| | | Mins | Hrs | Days | Never | Occasionally | Daily | > once a day |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

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

| List foods / beverages that you crave or 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 | > once a day |
| | | | | | | |
| | | | | | | |

DRUG

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):

| 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 |
|---------------------------------|---------------------------|---------------------------|-----------------------------|--|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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):

| 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 |
|---|---------------------------|---------------------------|-----------------------------|--|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

| Name of medication / anaesthetic / immunization | Type of side effects or allergic reaction that caused you to stop it | Treatment of side effects or reactions | Age | Year |
|---|--|--|-----|------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |

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? _____

Do you have an EpiPen or Twinject? No Yes → When was it prescribed? _____