

ENVIRONMENTAL HEALTH CLINIC

Pre-Visit Questionnaire

The information you provide on this form may be shared with your family doctor and other physicians involved in your care, and, on request, with third parties (e.g. insurance companies or lawyers etc.) to whom you have given consent for release of your medical information. Your medical record including this form may also be subjected to legal subpoena.

FOR OFFICE USE ONLY

Date Sent: _____ Date Received: _____
Date of Consultation: _____ Chart Number: _____
Start Time: _____ Stop Time: _____

PATIENT INFORMATION *(please print)*

Name: _____
Last First Middle

Health Card Number: _____ Preferred Name to Call You: _____

Address: _____
Street Apt. #

City / Town Province Postal Code

Phone: Home (_____) _____ — _____ Work (_____) _____ — _____ Cell (_____) _____ — _____

May we leave messages for you at WORK No Yes, HOME No Yes, FAX No Yes, EMAIL No Yes

Fax: (_____) _____ — _____ Email: _____ Sex: M F

Age: _____ Date of Birth: _____ / _____ / _____ Place of Birth: _____
year month day Country Province/State City/Town

Do you have: drug plan dental plan extended benefits plan Insurance Company: _____

Are you receiving benefits: short-term disability long-term disability CPP ODSP WSIB

Do you currently have any unresolved legal matters? No Yes If yes, please specify: _____

REFERRING DOCTOR

Name: _____

Address: _____
Street Suite #

City / Town Province Postal Code

Telephone: (_____) _____ — _____ Fax: (_____) _____ — _____

FAMILY DOCTOR

Same as above I do not have a family doctor.

Name: _____

Address: _____
Street Suite #

City / Town Province Postal Code

Telephone: (_____) _____ — _____ Fax: (_____) _____ — _____

How did you hear about this clinic? _____

How do you hope we may be able to help you? _____

Health History

MAIN SYMPTOM(S) THAT BRING YOU TO THIS CLINIC AND DATE(S) WHEN FIRST BEGAN:

Date when you last felt consistently well: _____

STORY OF MAIN SYMPTOM(S)

Please tell us your story of the **main symptoms** that bring you to the Environmental Health Clinic:

- from the *beginning up to now*
- any *times* or *places* symptom(s) *worse* or *better*
- *anything* you have *noticed made* symptom(s) *worse* or *better*
- any *diagnoses* you have been given and *by whom*

BEGINNING OF MAIN SYMPTOMS

Do you remember any events or illnesses that may have contributed to the beginning of your main symptoms?

[please check all boxes that apply, specify as requested and write date(s) as closely as you can remember]

How much contribution do you think each event or illness made to the beginning of your main symptoms? (Please circle one number for each.)

	Date(s)	None	A little	Some	Moderate	Strong	Don't know
<input type="checkbox"/> virus, bacterial or parasite infection \Rightarrow type: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> use of antibiotics \Rightarrow antibiotic name: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> serious illness, not infection \Rightarrow type: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> dental problems – fillings, root canals, dentures \Rightarrow specify: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> surgery \Rightarrow type: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> injury / accident \Rightarrow type: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> pregnancy / childbirth	_____	0	1	2	3	4	5
<input type="checkbox"/> menopause	_____	0	1	2	3	4	5
<input type="checkbox"/> start or change of medication / vaccination \Rightarrow medication name: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> blood transfusion	_____	0	1	2	3	4	5
<input type="checkbox"/> alcohol or drug abuse	_____	0	1	2	3	4	5
<input type="checkbox"/> family problems \Rightarrow specify: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> loss or illness of someone close to you \Rightarrow specify: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> change in marital status \Rightarrow specify: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> financial set-back	_____	0	1	2	3	4	5
<input type="checkbox"/> emotional problems \Rightarrow specify: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> physical, emotional or sexual abuse issues	_____	0	1	2	3	4	5
<input type="checkbox"/> change in place of residence \Rightarrow (location) from _____ to _____	_____	0	1	2	3	4	5
<input type="checkbox"/> renovation(s) at home \Rightarrow specify: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> chemical / toxic exposure <input type="radio"/> pesticides <input type="radio"/> solvents <input type="radio"/> other as an adult \Rightarrow specify: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> chemical / toxic exposure <input type="radio"/> pesticides <input type="radio"/> solvents <input type="radio"/> other in childhood \Rightarrow specify: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> change in workplace \Rightarrow (location) from _____ to _____	_____	0	1	2	3	4	5
<input type="checkbox"/> renovation(s) at work \Rightarrow specify: _____	_____	0	1	2	3	4	5
<input type="checkbox"/> change in job \Rightarrow (description) from _____ to _____ \Rightarrow if stopped working, please specify date last worked _____	_____	0	1	2	3	4	5
<input type="checkbox"/> other events / illnesses (please specify) _____	_____	0	1	2	3	4	5
_____	_____	0	1	2	3	4	5
_____	_____	0	1	2	3	4	5
_____	_____	0	1	2	3	4	5
_____	_____	0	1	2	3	4	5

Health History Summary From Birth to Present

Please summarize, in order from birth to present, using additional paper if necessary:

ALL SURGERIES, HOSPITALIZATIONS, SERIOUS, RECURRENT, OR CHRONIC ILLNESSES, INJURIES you have had. If females, include any **PREGNANCIES** and **ANY COMPLICATIONS**.

Age <small>(start at birth)</small>	Year <small>(approx.)</small>	Summary of Health Problems <small>List surgeries, hospitalizations, serious, recurrent, or chronic illnesses, injuries (e.g. pneumonia, TB, ulcer, gall bladder trouble, hepatitis, etc.)</small>	For Office Use ONLY

Help for Health Problems

What have you found MOST helpful for your present health problem(s)? _____

How many visits have you had to your continuing care family physician in the last 12 months? _____

What other doctors have you seen besides your continuing care family physician? *(please check all that apply)*

✓	Type of Physician	Name	Reason(s) seen	When <i>specify year(s)</i>	No. of Visits in last 12 months
	Allergist / Immunologist				
	Cardiologist (<i>Heart</i>)				
	Dermatologist (<i>Skin</i>)				
	Endocrinologist (<i>Gland</i>)				
	Environmental Physician				
	Gastroenterologist (<i>Stomach / Bowel</i>)				
	General Surgeon				
	Gynecologist				
	Hematologist (<i>Blood</i>)				
	Neurologist				
	Occupational Physician				
	Ophthalmologist (<i>Eye</i>)				
	Orthopaedic Specialist (<i>Bone</i>)				
	Otolaryngologist (<i>Ear, Nose, Throat</i>)				
	Physiatrist (<i>rehab</i>)				
	Psychiatrist				
	Respirologist (<i>Lung</i>)				
	Rheumatologist (<i>Joint / Muscle</i>)				
	Other(s) (<i>please specify</i>)				

What other health care professionals / providers have you seen? *(please check all that apply)*

✓	Type of Health Care Provider	Name	Reason(s) seen	When <i>specify year(s)</i>	No. of Visits in last 12 months
	Acupuncturist				
	Chiropractor				
	Dentist				
	Dental Hygienist				
	Dietitian				
	Herbalist				
	Homeopath				
	Massage Therapist				
	Naturopath				
	Nutritionist				
	Occupational Therapist				
	Optometrist				
	Physiotherapist				
	Psychologist				
	Public Health Nurse				
	Respiratory Therapist				
	Social Worker				
	Other(s) (<i>please specify</i>)				

Body Systems Survey

In general, how has your health been in the last 12 months?

- excellent
 very good
 good
 satisfactory
 fair
 poor
 extremely poor

Have you had any of the following symptoms in the last 12 months? *(please check all that apply)*

1. Constitutional and Endocrine (Glandular) Symptoms

- night sweating \Rightarrow How often? _____
- excessive daytime sweating \Rightarrow Triggers? _____
- unexplained body odour
- feeling cold \Rightarrow How often? _____
- cold hands / cold feet \Rightarrow How often? _____
- fever \Rightarrow Degree (in °C / °F) _____ \Rightarrow How often? _____
- significant weight gain \Rightarrow When? _____
 How many pounds or kilograms? _____ In how long? _____
- significant weight loss \Rightarrow When? _____
 How many pounds or kilograms? _____ In how long? _____

If normal energy is "9 – 10," in the last 12 months, on average, what energy have you had?

- On a good day? _____ / 10 \Rightarrow Number of good days / week _____
 On a bad day? _____ / 10 \Rightarrow Number of bad days / week _____

On average, how tired have you felt (in the last 12 months) compared to when you were last consistently well?

- no difference
 a little more tired
 somewhat more tired
 a lot more tired

Is your tiredness relieved by rest? No Yes \Rightarrow If yes, always sometimes

On average, how much is your tiredness relieved?
 a little some a lot completely

In the last 12 months, how many hours per day of useable energy have you had on average (i.e. able to do activities)?

- On a good day \Rightarrow Number of hours: _____
 On a bad day \Rightarrow Number of hours: _____

In the past 12 months, on average how many days a week have you spent most of the time in bed unable to do activities? _____

In the past 12 months, on average how many days a week are you unable to socialize due to symptoms? _____

2. Nervous System Symptoms

(if you have noticed anything triggers your symptoms or helps relieve them, please specify)

	Triggers	Helpers
<input type="checkbox"/> migraine \Rightarrow How often? _____ Location: _____ Associated vision changes? \Rightarrow <input type="radio"/> No <input type="radio"/> Yes <i>(please specify)</i> _____		
<input type="checkbox"/> other headaches \Rightarrow How often? _____ Location: _____ Type <i>(please specify)</i> _____		
<input type="checkbox"/> epileptic seizures		
<input type="checkbox"/> bumping into things, clumsiness, unsteadiness on feet		
<input type="checkbox"/> lightheadedness		
<input type="checkbox"/> dizziness (spinning)		
<input type="checkbox"/> unexplained falls		
<input type="checkbox"/> "pins and needles" feelings		

\rightarrow see next page

Have you had any of the following symptoms in the last 12 months? (please check all that apply)

2. Nervous System Symptoms [continued]

(if you have noticed anything *triggers* your symptoms or *helps* relieve them, please specify)

- dull, groggy
- spacey
- difficulty concentrating
- trouble finding words
- forgetfulness of recent events
- difficulty learning new information
- anxiety, tension
- excessive fears
- panic attack(s)
- difficulty sitting still, restlessness
- mood swings
- Depression ☞ Please rate on average from 1=very mild to 10=suicidal (circle one) 1 · 2 · 3 · 4 · 5 · 6 · 7 · 8 · 9 · 10
- feeling excessive guilt
- loss of interest
- hopelessness
- feelings of harming yourself
- increased irritability
- tendency to excessive anger
- Sleep Problems:
 - sleeping more than usual sleeping less than usual
 - ☞ average number of hours slept per night _____
 - ☞ average number of hours slept in 24 hours _____
 - problems getting to sleep
 - interrupted sleep / problems staying asleep
 - snoring
 - nightmares
 - waking unrefreshed
 - jerking of limbs
- other(s) (please specify) _____

<u>Triggers</u>	<u>Helpers</u>

3. Eyes, Ears, Nose, Throat (if you have noticed anything *triggers* your symptoms or *helps* relieve them, please specify)

- Symptoms
- ① Eyes dark circles
 - itchy
 - burning, watering
 - sticky, discharging
 - redness
 - difficulty focusing / blurred vision
 - loss of vision
 - eye pain
 - swelling of eyelid(s)
 - sensitivity to light
 - other(s) (please specify) _____

<u>Triggers</u>	<u>Helpers</u>

Have you had any of the following symptoms in the last 12 months? (please check all that apply)

3. Eyes, Ears, Nose, Throat [continued]

(if you have noticed anything triggers your symptoms or helps relieve them, please specify)

	Symptoms	Triggers	Helpers
② Ears	<input type="checkbox"/> itchy		
	<input type="checkbox"/> infection → when? _____		
	<input type="checkbox"/> fluid leaking		
	<input type="checkbox"/> full or blocked sensations in ear(s)		
	<input type="checkbox"/> decreased hearing		
	<input type="checkbox"/> ringing (tinnitus)		
	<input type="checkbox"/> sensitivity to noise		
	<input type="checkbox"/> other(s) (please specify) _____		
③ Nose	<input type="checkbox"/> itchy		
	<input type="checkbox"/> burning		
	<input type="checkbox"/> sneezing, running, congested, postnasal drip without a cold		
	<input type="checkbox"/> bleeding		
	<input type="checkbox"/> sinus fullness or stuffiness		
	<input type="checkbox"/> sinus pain or discharge		
	<input type="checkbox"/> upper respiratory infection (cold) → number of months (in last 12 months) you had a cold _____ → average duration _____		
	<input type="checkbox"/> stronger sense of smell than the average person		
	<input type="checkbox"/> smells are sickening → please specify which smell(s) _____		
	<input type="checkbox"/> other(s) (please specify) _____		
	④ Mouth, Throat	<input type="checkbox"/> cold sores	
<input type="checkbox"/> itchy			
<input type="checkbox"/> cankers			
<input type="checkbox"/> bad or metallic taste			
<input type="checkbox"/> coated tongue			
<input type="checkbox"/> gum problems			
<input type="checkbox"/> dental or denture problems → specify: _____			
<input type="checkbox"/> root canals → Number: _____ → Problems: _____			
<input type="checkbox"/> unexplained bad breath			
<input type="checkbox"/> sore throat			
<input type="checkbox"/> hoarseness or loss of voice			
<input type="checkbox"/> other(s) (please specify) _____			

→ see next page

Have you had any of the following symptoms in the last 12 months? *(please check all that apply)*

4. Lungs *(if you have noticed anything triggers your symptoms or helps relieve them, please specify)*

<u>Symptoms</u>	<u>Triggers</u>	<u>Helpers</u>
<input type="checkbox"/> cough		
<input type="checkbox"/> phlegm		
<input type="checkbox"/> tight chest		
<input type="checkbox"/> wheezing		
<input type="checkbox"/> shortness of breath		
<input type="checkbox"/> other(s) <i>(please specify)</i> _____		

5. Heart and Circulation *(if you have noticed anything triggers your symptoms or helps relieve them, please specify)*

<u>Symptoms</u>	<u>Triggers</u>	<u>Helpers</u>
<input type="checkbox"/> unexplained fast heartbeat		
<input type="checkbox"/> irregular heart beat		
<input type="checkbox"/> palpitations (heart pounding)		
<input type="checkbox"/> chest pressure / pain		
<input type="checkbox"/> heart murmur <i>(please specify)</i> _____		
<input type="checkbox"/> blood pressure problem <i>(please specify)</i> _____		
<input type="checkbox"/> unusual flushing		
<input type="checkbox"/> colour changes in fingers		
<input type="checkbox"/> easy bruising		
<input type="checkbox"/> bleeding tendency		
<input type="checkbox"/> varicose veins		
<input type="checkbox"/> other(s) <i>(please specify)</i> _____		

6. Gastrointestinal (stomach and bowel)

(if you have noticed anything triggers your symptoms or helps relieve them, please specify)

<u>Symptoms</u>	<u>Triggers</u>	<u>Helpers</u>
<input type="checkbox"/> appetite change → <input type="radio"/> increase <input type="radio"/> decrease		
<input type="checkbox"/> nausea		
<input type="checkbox"/> burping / belching		
<input type="checkbox"/> heartburn		
<input type="checkbox"/> upper abdominal pain		
<input type="checkbox"/> gall bladder problem		
<input type="checkbox"/> yellow jaundice		
<input type="checkbox"/> bloating		
<input type="checkbox"/> flatulence (excess gas)		
<input type="checkbox"/> lower abdominal pain / discomfort		
<input type="checkbox"/> constipation		
<input type="checkbox"/> diarrhea		
<input type="checkbox"/> mucous in stools		
<input type="checkbox"/> black tarry stools		
<input type="checkbox"/> blood in stools		
<input type="checkbox"/> rectal itching / burning		
<input type="checkbox"/> incontinence of stool		
<input type="checkbox"/> hernia <i>(specify type)</i> _____		
<input type="checkbox"/> other(s) <i>(please specify)</i> _____		

Have you had any of the following symptoms in the last 12 months? (please check all that apply)

7. Genitourinary (if you have noticed anything triggers your symptoms or helps relieve them, please specify)

<u>Symptoms</u>	<u>Triggers</u>	<u>Helpers</u>
<input type="checkbox"/> bladder infection → number of infections in last 12 months _____		
<input type="checkbox"/> passing your urine more frequently		
<input type="checkbox"/> pain / discomfort when or after passing urine		
<input type="checkbox"/> discomfort in lower abdomen associated with urination		
<input type="checkbox"/> getting up at night to pass your urine → How many times a night? _____		
<input type="checkbox"/> feeling as if bladder is not totally empty after voiding		
<input type="checkbox"/> leaking urine (e.g. when coughing or laughing)		
<input type="checkbox"/> decreased sex drive		
<input type="checkbox"/> sexually transmitted disease → if you ever had it, please specify the type(s) and year(s) _____		
Have you ever had test(s) for HIV? <input type="checkbox"/> No <input type="checkbox"/> Yes → result(s) and the year(s) _____		
<input type="checkbox"/> other(s) (please specify) _____		
① For Men Only		
<input type="checkbox"/> problems starting flow of urine		
<input type="checkbox"/> slower flow of urine		
<input type="checkbox"/> discharge from penis		
<input type="checkbox"/> trouble getting or sustaining an erection		
<input type="checkbox"/> discomfort in testicles or base of penis		
<input type="checkbox"/> lump(s) in testicle(s)		
<input type="checkbox"/> prostate problem (please specify) _____		
② For Women Only		
<input type="checkbox"/> vaginal discharge → colour _____ → if you ever had vaginal infection(s), specify the year(s), # of infections & types _____		
<input type="checkbox"/> vaginal itch		
Do you still have periods? <input type="checkbox"/> No → specify the year stopped _____ → <input type="radio"/> hysterectomy <input type="radio"/> menopause		
<input type="checkbox"/> Yes → <input type="radio"/> irregular <input type="radio"/> regular → every _____ days · Usual length of periods → _____ days · Usual flow → <input type="radio"/> light <input type="radio"/> moderate <input type="radio"/> heavy		
<input type="checkbox"/> painful periods with cramps		
<input type="checkbox"/> PMS (premenstrual symptoms) → (specify) _____		
<input type="checkbox"/> ovary pain or problem → Have you ever been diagnosed with ovarian cyst(s)? <input type="radio"/> No <input type="radio"/> Yes → When? _____		
<input type="checkbox"/> painful intercourse		
Approximately when did you have your last Pap smear (e.g. January 2003)? _____		
<input type="checkbox"/> breast problem → <input type="radio"/> pain <input type="radio"/> lump(s) or cyst(s) → if you have ever had lump(s) or cyst(s) treated, please specify result(s) and the year(s) _____		
Have you had mammogram(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes → please specify the year(s) and result(s) _____		

**Have you had any of the following symptoms
in the last 12 months?** (please check all that apply)

8. Musculoskeletal (if you have noticed anything *triggers* your symptoms or *helps* relieve them, please specify)

Symptoms

- muscle discomfort / pain not related to over-exercise
 - upper body left side upper body right side
 - lower body left side lower body right side
 - neck muscles mid back lower back
- muscle pain after exercise associated with activities of daily living (e.g. doing laundry, walking up stairs, etc.)

⇒ number of hours of pain _____ OR number of days of pain _____
- fatigue after exercise associated with activities of daily living (e.g. doing laundry, walking up stairs, etc.)

⇒ number of hours of fatigue _____ OR number of days of fatigue _____
- number of minutes you can comfortably walk per day

⇒ on a good day _____ on a bad day _____
- generalized muscle weakness ⇒ constant off and on
- weakness in particular muscles ⇒ please specify where _____
- joint problems ⇒ please check all joints that have been painful, swollen or red:

	painful	swollen	red		painful	swollen	red
left shoulder				right shoulder			
left elbow				right elbow			
left wrist				right wrist			
left hand				right hand			
left fingers				right fingers			
left hip				right hip			
left knee				right knee			
left ankle				right ankle			
left foot				right foot			
left toes				right toes			

- back joint problems ⇒ neck upper back mid back lower back
- other(s) (please specify) _____

9. Skin (if you have noticed anything *triggers* your symptoms or *helps* relieve them, please specify)

- generalized itching OR itchy areas ⇒ please specify: _____
- hives
- unexpected hair loss ⇒ please specify where: _____
- excessive dry or flaky skin
- eczema
- acne ⇒ antibiotic used? No Yes → length of time used: _____
- psoriasis
- athlete's foot or ringworm
- nail problems ⇒ please specify (e.g. fungal infection, etc.): _____
- cracking heels or finger tips
- pre-cancer spots ⇒ If you have ever had a skin cancer removed, please specify type(s) and the year(s) _____
- other(s) (please specify) _____

Triggers

Helpers

IMMUNIZATION HISTORY

Have you had the following immunizations?

- BCG (for TB)
- Hepatitis A
- Meningitis
- Chicken Pox
- Rubella
- Tetanus ⇒ Year of last booster: _____
- Polio ⇒ Year of last booster: _____
- Influenza ⇒ Year of last booster: _____
- Hepatitis B ⇒ Year of last booster: _____
- Other(s) ⇒ (please specify) _____

Family History

Relative	If Living				If Deceased		
	Present Age	Present Health Problems	Past Health Problems	Main Occupation	Age at Death	Date of Death	Cause of Death
Mother							
Father							
Sister(s) <i>(in age order from oldest to youngest)</i>							
Brother(s) <i>(in age order from oldest to youngest)</i>							
Spouse or Companion							
Previous Spouse <i>(if applicable)</i>							
Daughter(s) <i>(in age order from oldest to youngest)</i>							
Son(s) <i>(in age order from oldest to youngest)</i>							
Country of birth:	mother		mother's father (maternal grandfather)		mother's mother (maternal grandmother)		
	father		father's father (paternal grandfather)		father's mother (paternal grandmother)		

Has any blood relative of yours ever had any of the following conditions?

* Please check all that apply and specify relationship – immediate relatives (e.g. parents, brothers, sisters, children) and extended family (e.g. grandparents, aunts, uncles, cousins, etc.) on your mother's and father's sides.

* Please also specify type of condition (e.g. of cancer) or known triggers (e.g. of allergies).

✓	Condition	Immediate Relatives	Extended Family (Mother's side)	Extended Family (Father's side)	Type or known triggers
	Addiction				
	Allergies				
	Alzheimer's disease				
	Asthma				
	Bleeding tendency				
	Cancer				
	Chronic lung disease				
	Diabetes				
	Glaucoma				
	Heart disease				
	High blood pressure				
	Migraine				
	Nervous trouble				
	Stroke				
	Suicide				
	Thyroid trouble				
	Any other disease(s) that run(s) in your family?				

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 types)* _____

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:* _____

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

Age:	0-5	6-17	18-40	41-64	65+

Do you protect yourself from excess sun exposure? 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 Yes Mattress cover(s)? No Yes

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

Have any renovations been done since you've moved in? No Yes → When? _____ What? _____

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 _____ window cleaner _____

laundry detergent _____ liquid fabric softener _____ dryer sheets _____

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 <input type="checkbox"/> 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 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:*

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: <i>(please circle)</i>	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? <i>Specify year(s)</i>	Comments (e.g. who or circumstances involve)
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
	1.	2.	3.	
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 <u>crave</u> 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

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? _____