Environmental Factor Questionnaire

Name:_____

Please check those that apply.

☐ 1. Do you have amalgam (silver) fillings in your teeth?
☐ 2. Have you ever had them in the past?
☐ 3. Did your mother have amalgam when pregnant with you?
☐ 4. Have you ever worked in a dental office? If so, how long?_____
☐ 5. Have you had any dental crowns, bridges, root canals, dry sockets or infected tooth extractions?
☐ 6. Do you have any dental implants or other metal in your mouth?
☐ 7. Did you wear contact lenses during the 1980's or early 1990's?
☐ 8. Did you take oral contraceptives during the 1980's or early 1990's?
☐ 9. Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
☐ 10. Have you noticed any adverse reactions to these shots?
☐ 11. Do you have any tattoos with red ink?
☐ 12. Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?
☐ 13. Does your occupation involve soldering, metal salvage, old home repair or sandblasting?
☐ 14. Have you remodeled a home built before 1978?
☐ 15. Have you lived in a home built before 1978 for more than 5 years?
☐ 16. Have you ever worn cosmetics containing kohl?
☐ 17. Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain._____
_____
☐ 18. Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)
☐ 19. Have you worked with pesticide?
☐ 20. Have you worked with herbicides?
☐ 21. Have you been sprayed by either pesticides or herbicides?
☐ 22. Do you smoke cigarette or other tobacco products?
☐ 23. How old is the house you are living in? _____
How long have you lived there?_____
_____
☐ 24. Do you see mold growing at home, work or school?
☐ 25. Have you ever had water damage at home, work or school?
☐ 26. Do you feel better when away from your home?
☐ 27. Does your home, workplace or school have a damp or mildew smell?
☐ 28. Does spending time in your basement cause or worsen your symptoms?
☐ 29. Does your basement ever get wet?
☐ 30. Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?
☐ 31. Do you have problems with breathing in houses with molds?
☐ 32. Do musty odors bother you?
☐ 33. Have you worked or lived in a building where the air vents or ceiling tiles were discolored?
☐ 34. Have you noticed water damage or discoloration elsewhere?
☐ 35. Has your home been flooded?
☐ 36. Have you had leaks in the roof?
☐ 37. Do you experience unusual shortness of breath?
☐ 38. Do you experience recurring sinus infections?
☐ 39. Do you experience recurring respiratory infections and coughing?
☐ 40. Do you have frequent flu-like symptoms?
☐ 41. Do your symptoms worsen on rainy days?
☐ 42. Do you have frequent headaches?
☐ 43. Are you fatigued and have a skin rash?
☐ 44. Have you ever been diagnosed with Lyme disease?
☐ 45. Have you ever been bitten by a tick or recluse spider?
☐ 46. Have you ever seen a bulls-eye rash appear on any part of your body?
☐ 47. Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?
☐ 48. Was your mother ever diagnosed with Lyme Disease?
☐ 49. Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?_____
_____
☐ 50. Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
☐ 51. Do you have any history of kidney dysfunction?
☐ 52. Is there a family history of breast, uterine, cervical or other female cancers?
☐ 53. Is there a family history of PMS, fibroids or ovarian cysts?
☐ 54. Do you have any history of heart disease, myocardial infarction (heart attack), etc.?
☐ 55. Are you currently having any thoughts of suicide?
☐ 56. Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?
☐ 57. Do you have a history of strokes?
☐ 58. Have you ever been diagnosed with diabetes mellitus?
☐ 59. Have you ever been in an auto accident, fallen or received a major physical injury?
☐ 60. Are you in menopause?
☐ 61. Do you have any allergies to food or medication?
☐ 62. Do you find you need to take antihistamines regularly?

Check symptoms that occur when you are around electronics such as WIFI (especially G5), computer equipment, cellular towers, etc.:

☐ 1. Dizziness
☐ 2. General discomfort
☐ 3. Difficulties concentrating
☐ 4. Memory loss
☐ 5. Fatigue
☐ 6. Headache
☐ 7. Warmth behind/around ear
☐ 8. Warmth on ear
☐ 9. Burning skin
☐ 10. Itching
☐ 11. Tingling/tightness
☐ 12. Sleeping disorders
☐ 13. Tinnitus (ringing in ears)
☐ 14. Numbness
☐ 15. Palpitations
☐ 16. Pain in chest
☐ 17. Problems breathing
☐ 18. Difficulty concentrating
☐ 19. Irritability
☐ 20. Anxiety
☐ 21. Flu-like symptoms
☐ 22. Difficulty controlling your muscles
☐ 23. Spasms or muscle cramps

Are you chemically sensitive to:

☐ 1. paper
☐ 2. cardboard
☐ 3. press board furniture
☐ 4. ammonia
☐ 5. cleaning products
☐ 6. perfumes
☐ 7. air fresheners
☐ 8. specific medications (please specify:_____
_____
☐ 9. bleach
☐ 10. gas fumes
☐ 11. deodorant
☐ 12. hair spray
☐ 13. laundry detergent
☐ 14. scented candles
☐ 15. pesticides
☐ 16. fertilizers
☐ 17. natural gas
☐ 18. propane
☐ 19. cigarette smoke
☐ 20. nail polish
☐ 21. cosmetics
☐ 22. glues & adhesives
☐ 23. pollen
☐ 24. auto exhaust
☐ 25. Moth balls

In the area below, please provide any additional information (history of exposure to toxins, onset of problems, etc) that may help clarify problems you are experiencing.