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Patient Inquiries & Fax: (520) 586-9091
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IF YOU CANNOT KEEP YOUR APPOINTMENT: You must notify Progressive Healthcare (520-586-9111) 48 hours before your appointment (or sooner if possible) so that we can try to schedule another patient. If you do not notify us, you will be charged $100 for a missed visit.

This form must be filled out prior to each visit, if form is incomplete you may be asked to reschedule

Health & Environmental History Questionnaire

Name: _____ Date: _____

Address: _____ Age: _____
_____
_____

Home Phone:_____ Work Phone:_____

SS#_____ Date of birth:_____

Does your current health significantly reduce your ability to do your job, housework, chores and/or other needed activities? ____ No, ____ A Little, ____Moderately, ____Severely
IF YES, describe: _____
_____

DO NOT WRITE BELOW ON THIS PAGE – PROCEED TO PAGE 2

DIAGNOSIS: TE RADS ASTHMA CFS FM
Mycotoxicosis Other:_____

CASUAL EXPOSURE: HOME SCHOOL Rx WORK/GOV'T
WORK/PRIVATE OTHER UNKNOWN
If work, Employer_____

SITUATION OF EXPOSURE: PESTICIDE CARPET/RENOV SBS
MOLD OTHER_____

TOXIN/CHEM INVOLVED:_____

TOXIN/CHEMICAL PRODUCTS INVOLVED_____

_____

Patient Name:_____

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REFERRING DOCTOR:_____

MEDICAL

1. For each situation below, answer the questions at the top of each column. By "sick" we mean anything that YOU consider to be a major or a minor health problem.

EXPOSURES	Would you be sick if you had to spend 4 hours.....?					Would you be sick if you had to spend 20 minutes.....?				
	No	A little	Moderately	A lot	Don't know	No	A little	Moderately	A lot	Don't know
a. Next to someone smoking cigarettes outside										
b. Driving in heavy traffic with windows open										
c. Around workers tarring a road										
For the next questions, assume you are inside with no open windows.....										
d. In a room sprayed with pesticides 4 hrs ago										
e. In a room painted 24 hrs ago with water-based paint.										
f. Shopping in an enclosed mall										
g. In a room with wall-to-wall carpet(1 week old)										
h. Sitting next to a person wearing perfume/cologne.										
I. Cooking on a stove using natural gas										
j. Being around / using carbonless copy paper										
k. Sitting next to someone with fabric softener on clothing										
Would you be sick if you had to.....?						No	A little	Moderately	A lot	Don't know
l. Drink one glass of city (chlorinated) water?										
m. Try on newly dry cleaning clothing?										
n. Walk down the detergent aisle at a grocery store?										
o. Use self-service at a gas station?										
p. Use a bathroom with a scented air freshener?										
q. Read a freshly printed newspaper?										
r. Wear synthetic fabric?										
s. Swim for 20 minutes in a chlorinated pool?										
t. Wear clothing that has been laundered with chlorine bleach?										
u. Wear clothing that has been laundered with perfumed laundry soap?										
v. Use chlorine bleach in your toilet?										

2. Describe a typical reaction, listing symptoms in order of onset, and describing the time frame. If your reactions are quite different from time to time, describe this also._____

_____

_____

3. Please describe your AVERAGE reaction to a chemical exposure in a public place (fill in the correct number of minutes, hours, or days or check "no reaction" if your do not experience the problem):

Patient Name:_____

a. How long does it take before you feel as well as you did before the exposure?
___Minutes, or ___Hours, or ___Days, or ___ No reaction

b. How long does it take before you think as clearly as before it began?
___Minutes, or ___Hours, or ___Days, or ___ No reaction
c. How long is it before you recover energy to do most of your usual activities?
___Minutes, or ___Hours, or ___Days, or ___ No reaction
Describe typical symptoms you experience during such a reaction, if any. In the order they occur:_____

4. Do you feel that you have more health problems than you used to have when in certain places or around certain things?
□ No □ Yes □ Not sure
a. IF YES, When did you first notice this?_____ specify month & year
b. When do you remember last feeling really well, without any health problems around places or things?_____ specify month and year.

5. We will use these questions to evaluate your response to treatment. These questions ask about symptoms you may have experienced commonly. Rate the severity of your symptoms on a 0 – 10 scale; 0 = not at all a problem; 5 = moderate symptoms; 10 = disabling symptoms.

a. Problems with your head, such as headaches, or a feeling of pressure or fullness in your face or head?	0 1 2 3 4 5 6 7 8 9 10
b. Problems with your ability to thing, such as difficulty concentrating or remembering things, feeling spacy, or having trouble making decisions.	0 1 2 3 4 5 6 7 8 9 10
c. Problems with your mood, such as feeling tense or nervous, irritable depressed, having spells of crying or rage, or loss of motivation to do things that used to interest you?	0 1 2 3 4 5 6 7 8 9 10
d. Problems with your balance or coordination, with numbness or tingling in your extremities, or with focusing your eyes?	0 1 2 3 4 5 6 7 8 9 10
e. Problems with your muscles or joints such as pain, aching, cramping, stiffness or weakness?	0 1 2 3 4 5 6 7 8 9 10
f. Problems with your skin such as a rash, hives or dry skin?	0 1 2 3 4 5 6 7 8 9 10
g. Problems with your urinary tract or genitals, such as pelvic pain or frequent/urgent urination? (women: or discomfort or other problems with menstrual periods?)	0 1 2 3 4 5 6 7 8 9 10
h. Problems with your stomach or digestive tract, such as abdominal pain or cramping, abdominal swelling or bloating, nausea, diarrhea, or constipation?	0 1 2 3 4 5 6 7 8 9 10
I. Problems with your heart or chest, such as fast or irregular heart rate, skipped beats, your heart pounding, or chest discomfort?	0 1 2 3 4 5 6 7 8 9 10
j. Problems with burning or irritation of your eyes or problems with your airway or breathing, such as feeling short of breath, coughing, or having a lot of mucus, postnasal damage, or respiratory infections?	0 1 2 3 4 5 6 7 8 9 10

(Claudia Miller)

6. Have you seen a doctor(s) because of your health problems with certain places or things?
___Yes, ___ No. **IF YES,** ask your doctor(s) to provide you with a copy of your medical record and bring these medical records with you when you visit Dr. Gray for the first time. List below the doctor's name(s), the year(s) of your visits(s). starting with doctor you saw first. (Use extra paper if needed).

DOCTOR ADDRESS/PHONE YEAR(S)

Patient Name:_____

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_____
_____
_____

7. On a separate piece of paper, please type (or neatly print) a narrative describing how and when your illness began. Describe in time order from the beginning and list dates as often as possible. If one (or more) exposures were involved, describe where you were in relation to it, how long you were exposed, what your symptoms were, and how soon after exposure those symptoms developed.

8. Do you have pain once a week or more? □ No □ Yes
   a. If yes, how often? □ Weekly □ 2-4 times a week □ Almost daily □ Other _____
   b. How severe is the pain usually? □ Mild □ Moderately □ Severe
   c. How long does it usually last? □ 1 hr or less □ 2-4 hrs □ 5-8 hrs □ Other __hrs __days
   d. Where is the pain?

_____
_____

9. List all the medications that you are currently taking, the dose and how often you take them, what they are for, whether they help, and what bothersome side effects you experience. If you have any doubt about your answers, bring the medication bottles(s) with you to your appointment. Include any shots or medications for allergies:

Name of Medication **Dose/Frequency** **Purpose** **Helps?** **Side Effects**

_____
_____
_____

10. Please describe your health and life as accurately as your can before and after your exposure or chronic illness.

	Never	Rarely	Some times	Often	Most of the time
a. Difficulty thinking clearly .					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
b. Trouble understanding others.					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
c. Get lost.					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
d. Forget what someone tells me.					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
e. Trouble understanding what I read					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
f. Forget what I read					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
g. Muscle twitching					
Before exposure/illness					

Patient Name:_____

Right after exposure/illness					
Past 6 months					
h. Muscle spasms.					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
I. Seizures or Fits.					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
j. Blurred vision.					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
k. Reduced hearing.					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
l. Poor balance.					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
m. Poor sense of smell.					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
n. Numbness, Tingling in arms or legs					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
o. Dropping things					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					
p. Tremor, shaking					
Before exposure/illness					
Right after exposure/illness					
Past 6 months					

(Raymond Singer, PhD)

Patient Name:_____

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11. For the symptoms and health problems listed below. If you have had the problem in the last year, **CIRCLE** the number that best describes how often the symptom occurs, or circle 7 if not sure.

A. Davidoff Inflammatory Symptom Frequency Profile.

	Daily to Almost Daily	Several Times/ Week	Once A Week	Several Times/ Month	Once/ Month or Less	Rarely if ever
1. Headaches	1	2	3	4	5	6
2. Numbness, tingling	1	2	3	4	5	6
3. Weakness in a body part	1	2	3	4	5	6
4. Lightheadedness and dizziness	1	2	3	4	5	6
5. Tremor or shaking	1	2	3	4	5	6
6. Muscle twitching	1	2	3	4	5	6
7. Confusion, spaciness, inability to concentrate	1	2	3	4	5	6
8. Memory problems	1	2	3	4	5	6
9. Slurred words, difficulty finding words	1	2	3	4	5	6
10. Coordination difficulties	1	2	3	4	5	6
11. Low energy, fatigue (unusual)	1	2	3	4	5	6
12. Dizziness when standing up after sitting	1	2	3	4	5	6
13. Shakiness relieved by eating	1	2	3	4	5	6
14. Poor appetite	1	2	3	4	5	6
15. Sweet cravings	1	2	3	4	5	6
16. Unusual thirst	1	2	3	4	5	6
17. Itchy, watery eyes and nose	1	2	3	4	5	6
18. Visual changes	1	2	3	4	5	6
19. Ringing of the ears	1	2	3	4	5	6
20. Changes in hearing	1	2	3	4	5	6
21. Nasal symptoms (discharge, stuffiness)	1	2	3	4	5	6
22. Sinus discomfort	1	2	3	4	5	6
23. Throat discomfort(soreness, tightness)	1	2	3	4	5	6
24. Weak voice with hoarseness	1	2	3	4	5	6
25. Reduced cold tolerance	1	2	3	4	5	6
26. Reduced heat tolerance	1	2	3	4	5	6
27. Swollen glands	1	2	3	4	5	6
28. Coughing	1	2	3	4	5	6
29. Chest discomfort (heaviness, pain)	1	2	3	4	5	6

	Daily to Almost Daily	Several Times/ Week	Once A Week	Several Times/ Month	Once/ Month or less	Rarely if ever
30. Chest tightness	1	2	3	4	5	6
31. Wheezing	1	2	3	4	5	6
32. Muscle discomfort and spasm	1	2	3	4	5	6
33. Joint discomfort	1	2	3	4	5	6
34. Rapid pulse	1	2	3	4	5	6
35. Palpitations (rapid, violent throbbing, extra or skipped beats)	1	2	3	4	5	6
36. Swelling of the ankles	1	2	3	4	5	6
37. Bruising without cause	1	2	3	4	5	6
38. Itching, rash, hives	1	2	3	4	5	6
39. Flushing of the skin	1	2	3	4	5	6
40. Reduced bladder control	1	2	3	4	5	6
41. Need to pass urine frequently	1	2	3	4	5	6
42. Insomnia	1	2	3	4	5	6
43. Frequent jerking during sleep	1	2	3	4	5	6
44. Loud snoring during sleep	1	2	3	4	5	6
45. Stopping breathing during sleep	1	2	3	4	5	6
46. Unwanted falling asleep during the daytime	1	2	3	4	5	6
47. Fingertips turning white or blue	1	2	3	4	5	6
48. Menstrual changes (women)	1	2	3	4	5	6
49. Impotence with reduced ability to maintain an erection (men)	1	2	3	4	5	6
50. Significantly reduced sex drive	1	2	3	4	5	6
51. Pain, burning in the genital area	1	2	3	4	5	6
52. Painful intercourse or other sexually related problems (circle)	1	2	3	4	5	6
53. Difficulty or discomfort with swallowing	1	2	3	4	5	6
54. Reflux of stomach acid	1	2	3	4	5	6
55. Nausea, vomiting	1	2	3	4	5	6
56. Bloating, gas	1	2	3	4	5	6
57. Abdominal discomfort (pressure, pain or cramps)	1	2	3	4	5	6
58. Other (specify): _____	1	2	3	4	5	6

Patient Name:_____

12. Before your current illness were you ever diagnosed with a psychiatric disorder?
☐ No ☐ Yes ☐ Not Sure
IF YES please explain:_____
_____

IF YES, were you hospitalized for it ☐ No ☐ Yes, When:_____

13. Would you have limitations if your work required you to do the following:
a. Lift and carry ☐ No Limitation ☐ Limited
If you were asked to spend up to a third of your work day lifting and carrying, what is the maximum number of pounds that you could lift and carry. _____
b. Stand and/or walk: ☐ No Limitation ☐ Limited
How long can you do this at a time?_____ hours.
How long can you do this total daily? _____ hours.
c. Sit ☐ No Limitation ☐ Limited
How long can you sit in an office chair at a time? _____ hours
How long total in a work shift? _____ hours
d. Push and/or pull (include hand and foot controls) ☐ No Limitation ☐ Limited
_____

14. Does your medical condition interfere with your ability to do any of the following:
If it doesn't apply to you check "N/A" (Not Applicable). Also describe any problems.

	No	Yes a little	Yes moderately	Yes a lot	N/A	
Climbing stairs?						
Sitting longer than 1 hr?						
Standing longer than 1 hr?						
Frequent bending?						
Frequent twisting?						
Thinking clearly while reading?						
Thinking clearly while doing simple arithmetic?						
Remembering and following instructions?						
Writing/typing over 1 hr?						
Driving a car in heavy traffic?						
Household chores – scrubbing floors						
Washing windows/car						
Vacuuming/Sweeping						
Carrying groceries, 10-15 lbs?						
Going to public places						
Frequent lifting 5-10 lbs						
Frequent walking (short distances)						
Interacting with people						
Maintaining regular work schedule						

15. Do you have persistent or relapsing chronic fatigue? ☐ No ☐ Yes
If Yes when did this start? Approximate date:_____
Do you have fatigue without exerting yourself? ☐ No ☐ Yes ☐ Not sure
Does rest largely fail to relieve your fatigue? ☐ No ☐ Yes ☐ Not sure
Has your fatigue resulted in substantial reduction in previous levels of:
Occupational activity ☐ No ☐ Yes ☐ Not sure
Social activity ☐ No ☐ Yes ☐ Not sure
Personal activity ☐ No ☐ Yes ☐ Not sure

Patient Name:_____

_____ activity ☐ No ☐ Yes ☐ Not sure

16. Has your activity level been reduced to less than half of what it was before by your fatigue/illness?
☐ No ☐ Yes ☐ Not sure

Check yes if you have any of the following problems (persisting or on and off) for 6 months or more AND IF the problem was not significant before your fatigue began:

Impairment of concentration or short tern memory	☐ No	☐ Yes	☐ Not sure
Sore throat	☐ No	☐ Yes	☐ Not sure
Tender lymph glands in neck or armpits	☐ No	☐ Yes	☐ Not sure
Muscle pain	☐ No	☐ Yes	☐ Not sure
Pain in multiple joints without redness or swelling	☐ No	☐ Yes	☐ Not sure
Headache of a new type, pattern or severity?	☐ No	☐ Yes	☐ Not sure
Unrefreshing sleep?	☐ No	☐ Yes	☐ Not sure
Fatigue lasting over 24 hrs after exertion?	☐ No	☐ Yes	☐ Not sure

If fatigue is present, what are the precipitating factors or types of activities that bring on fatigue, and how soon after starting the activity does the fatigue begin (describe)?

_____
_____
_____

If fatigue is present, how long must you rest before you can engage in activities again?

_____

Do you feel worse after exercise and exhausted the next day? ☐ No ☐ Yes

In the last year, are you:

☐ Much better ☐ A little better ☐ The same
☐ A little worse ☐ Much worse

On most days, do you usually feel:

☐ fairly well with no severe symptoms, able to do all normal work/housework.
☐ mildly ill with few if any severe symptoms, able to do almost all normal work/housework.
☐ moderately ill with some severe symptoms, able to do some work/housework with limits.
☐ Very ill with many severe symptoms, unable to do normal work/housework.

Describe your activities for a relatively typical day in the past month:

_____
_____
_____
_____

Have you noticed symptoms increase when using telephones, remote control devices, or answering machines? ☐ No ☐ Yes ☐ Not sure
(if you only experience this with devices that are less than a year old and plastic, indicate this)

Have you ever been in a hospital overnight (inpatient)?

Name of hospital City Year Medical problem

_____
_____
_____
_____

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If you have had any of the following medical problems, circle them and write the year(s) that the problem was present. If it is present, put "TO NOW" after the year it started.

Adrenal insufficiency	Hay fever	Pneumonia
Alcohol problem	Heart disease	Polycythemia Vera
Anemia, hemolytic	Hepatitis chronic	Polymyositis
Anemia, Iron deficiency	Herpes	Prophyrin Disturbance
Anemia, Pernicious	HIV	Rheumatoid Arthritis
Arthritis	Hormone Deficiency	Scleroderma
Asthma	Hyperactivity	Sinus problems
Attention Deficient disorder	Infections, frequent	Sjogren's disease
Autoimmune problem	Kidney Infections	Smell, reduced sense of
Bladder infections	Liver disease	Sugar, low blood
Bloof pressure, high	Lupus	Thrombangitis obliterans
Chronic fatigue syndrome	Migraine	Thrombocytopenia purpura
Cirrhosis (of liver)	Mitral valve prolapse	Thyroid, overactive
Colitis, Ulcerative	Multiple Sclerosis	Thyroid, underactive
Crohn's disease	Myasthenia Gravis	Thyroiditis
Diabetes	Nutritional Deficiency, Type	Vasculitis
Eczema		Vitamin Deficiency
Epilepsy or seizures	Ovarian Cyst	Yeast problem
Fibromyalgia	Ovarian Failure	Other (list)
Graves' Disease	Parasite Infection	

	Yes	No	Not Sure
Do you have symptoms made worse by exposure to sunlight? II YES Are they □ skin and/or □ Other Describe:			
Has your urine ever been □ Dark brown, □ green or □ pink-red (not due to blood)			
IF YES was this shortly after an exposure that increased your symptoms? IF YES when was the last time? Approximate Date:			
Do you have abdominal pain? IF YES is this pain □ Chronic and/or □ worse after an exposure?			
Are any of your symptoms made worse by dieting or skipping meals?			
Are any of your symptoms made worse by drinking just one glass of beer or wine?			
Are your symptoms made worse by medication?			
Do you get any skin symptoms from medications or exposures?			
Do you get any skin symptoms from wearing copper bracelets or other metal objects (such as gold and silver watches, rings, jewelry etc?			
Are symptoms worse the week before your menstrual period (women only)			

Are your symptoms changed by eating □ No □ Increased □ Decreased
Are your symptoms changed by eating carbohydrates? □ No □ Increased □ Decreased

Have you ever smoked cigarettes: □ No □ Yes
IF YES what year did you begin? 19___ How many packs a day on average? ____/day?
Have you stopped smoking? □ No □ Yes IF YES what year did you stop? 19____

Do you experience increased mood swings or irritability with your illness compared to before?
□ No □ Yes
IF YES is this greater before breakfast in a.m. and/or late afternoon on an empty stomach?
□ No □ Yes □ Not sure
(If not sure, please keep a mood swing diary, listing the date, time, time of day and the number of hours since last

Patient Name:_____

meal or smack-indicate which-for all episodes of sudden or unexpected sadness or irritability, for at least a week
or 6 episodes, and bring or send this to us.)

If you have been diagnosed with an allergy or intolerance to any of the following, please enter the year that the condition began or was diagnosed:
Foods, since 19___ Types of foods:_____
Mold, since 19___ Pollen, since 19___ Dander, since 19___ Duse, since 19___
Other allergies (including medications) Since 19___
_____

Do you usually buy foods grown without pesticides (organic)?
□ No □ Not sure □ Yes sometimes □ Yes, regularly

6. List all you ate & drank in the 4 days before your appointment. Eat according to your usual custom.

	Breakfast:	Lunch:	Dinner:	Other:
Day 1				
Day 2				
Day 3				
Day 4				

ON AVERAGE, how many times a day do you now drink:
Coke/Cola_____/Day Coffee_____/Day Tea (exclude herbal)_____/Day

Do you drink beer, wine, or other drinks containing alcohol? □ No □ Yes
IF YES about how many drinks on average a week? _____/week

Make a list of your questions and your goals for this visit. Use extra paper if needed.
Questions:_____
_____
_____
_____
Goals:_____
_____
_____
_____

WORK/SCHOOL ENVIROMENT. (If you have exposures at school but not work, describe here)

Beginning with your most recent job/school, list the years you were at them, and any chemicals you were exposed to while there. In the column marked "sick at work/school," write YES if you had (or have) an illness that you think was made worse by exposures there. You should also write YES if your health was (is) worse at work/school than away from there. Enter a "?" if you don't know and "NO" if you don't think your job/school made (or is making) you ill. IF school. Please circle school.

Patient Name:_____

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Employer/type of work/school years Chemicals/toxins near you Sick at work/school

_____

_____

_____

_____

HOME ENVIROMENT

Check below all that apply to your home.

	Yes	No	Not Sure	BEDROOM	Yes	No	Not Sure
Live in a condo/apartment				Carpet			
Chemical exposure				Synthetic Rugs			
Pesticides used in buildings				Windows open at night			
Live in mobile home				Plastic items			
Live in detached house I own				Particle board furnature			
Windows hard to open				Mattress, commercial			
Near busy road				Pillow-foam/synthetic			
Attached garage				Bedding-regular commercial			
Household carpet				Pillow-cotton/natural			
Damp basement				Mattress, cotton-no chemicals			
Nearby lawn chemicals used				Bedding-natural			
Plastic furniture				Foam stuffed furnature, toys			
Plywood furniture				Books, printed matter			
Particle board items							
Pressboard items				Is there an activated charcol filter in your....			
Recent painting				Brand			
Recent remodeling				Bedroom			
Recent pesticide use				Living area			
Gas furnace				Eating area			
Oil furnace				Car			
Gas stove				Drinking water			
Gas water heater				Shower			
Gas clothes dryer				Whole house water			
Fuel space heater (not electric)				Whole house air			
Wood stove				Electrostatic/ionizing filter			
Symptoms w/family exposures							
Humidifier-regular water used							
Humidifier-filtered water used				MOLD			
Well-water-no chemicals added				Visible mold growth in home			
Well water-chemicals added				Bedroom			
Teflon cookware				Other room-Name			
Aluminum cookware				Visible mold in work/school areas			

Did you ever live in a house/apt. That was treated with chlordane for termites?

☐ No ☐ Don't know ☐ Yes, current house/apt ☐ Yes, past house/Apt.

Have you sorted all your household products and eliminated pesticides, petrochemicals, and other irritating substances from your home?

(this includes cosmetics, personal hygiene products, cleaning agents, etc.)

☐ No ☐ Yes, some ☐ Yes, almost all

Is there anyone in your home/dwelling unit who uses products that seem to aggravate your symptoms?

☐ No ☐ Yes

IF YES please describe the situation.

_____

_____

Patient Name:_____

_____

Do you have a nearby nontoxic outdoor area, such as a large park or other wooded area, where you can walk without getting symptoms. ☐ Not Sure ☐ No ☐ Yes

IF YES are pesticides ever used in these locations? ☐ Not Sure ☐ No ☐ Yes

IF NOT SURE, please ask the owner/manager of the property before you visit.

How many hours a week, on average, are you outside in a nontoxic area? _____ hours.

Are you doing sauna treatments following exercise?

☐ No ☐ Yes, at home Sauna brand = _____

☐ Yes, commercial sauna ☐ Yes, Sauna at a Medical facility

Are you exposed to anything else of concern to you in your neighborhood?

☐ No ☐ Yes, of concern ☐ Yes, seems to make me sick

IF YES, describe:_____

_____

_____

_____

What other problems do you face with your health, if any: physical, emotional, socail, financial, sexual, legal, etc.

_____

_____

_____

_____

31. Has your health insurance covered most costs for:
    a. Medical visits? ___ Yes; ___ No
    b. Medical phone follow up? ___ Yes; ___ No

Please circle ONE response for each substance listed. In making you choise, the following definitions of symptoms should be used. A symptom means your awareness of some discomfort or

Currently Symptomatic	Formally Symptomatic	No Symptoms	No known exposure (Don't know)	Currently Symptomatic	Formally Symptomatic	No Symptoms	No known exposure (Don't know)	Currently Symptomatic	Formally Symptomatic	No Symptoms	No known exposure (Don't know)
Aerosol air freshener				Deodorizers in public restrooms				Fabric, permanent press finishes			
1	2	3	4	1	2	3	4	1	2	3	4
Aftershave				Detergent, liquid dishwashing				Fabric, Fabric			
1	2	3	4	1	2	3	4	1	2	3	4
Air conditioner				Detergent, dishwasher				Fabric, cotton			
1	2	3	4	1	2	3	4	1	2	3	4
Ammonia				Detergent, Laundry				Fabric, Nylon			
1	2	3	4	1	2	3	4	1	2	3	4
Asbestos				Diesel, exhaust				Fabric softener			
1	2	3	4	1	2	3	4	1	2	3	4
Asphalt pavements in hot weather				Down feather stuffing				Fertilizer, synthetic			
1	2	3	4	1	2	3	4	1	2	3	4
Carbonless copy paper				Dry cleaned clothes (recent)				Fertilizer, natural			
1	2	3	4	1	2	3	4	1	2	3	4
Ceder scented products				Dry cleaning spot remover				Fiberglass			
1	2	3	4	1	2	3	4	1	2	3	4
Chlordane				Dursban/Chloropyrifos				Flea collars			
1	2	3	4	1	2	3	4	1	2	3	4

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Chlorinated water				Dyes in clothes and leather				Floor wax			
1	2	3	4	1	2	3	4	1	2	3	4
Cleaner, floor				Dyes in cosmetics				Foam rubber stuffing			
1	2	3	4	1	2	3	4	1	2	3	4
Copy machines				Electric range				Fuel, Diesel			
1	2	3	4	1	2	3	4	1	2	3	4
Correction fluid (White-out)				Fabric, rayon				Fumes, garage			
1	2	3	4	1	2	3	4	1	2	3	4
Deodorant, aerosol				Fabric, polyester				Fumes, roofing/road tar			
1	2	3	4	1	2	3	4	1	2	3	4
Deodorant, roll-on				Fabric, silk				Furniture polish			
1	2	3	4	1	2	3	4	1	2	3	4
Gas, natural				Mimeograph machines				Scouring powder (with bleach)			
1	2	3	4	1	2	3	4	1	2	3	4
Gas range				Moth balls				Scouring powder (without bleach)			
1	2	3	4	1	2	3	4	1	2	3	4
Gasoline				Nail polish				Shampoo			
1	2	3	4	1	2	3	4	1	2	3	4
Gasoline exhaust				Nail polish remover				Shoe polish			
1	2	3	4	1	2	3	4	1	2	3	4
Glue, epoxy				New car smell				Shoe waterproofer			
1	2	3	4	1	2	3	4	1	2	3	4
Glue, rubber cement				Newsprint				Smoke, pipe			
1	2	3	4	1	2	3	4	1	2	3	4
Hair dye/ hair bleach				Oil burner exhaust				Smoke, barbecue			
1	2	3	4	1	2	3	4	1	2	3	4
Hair spray				Oven cleaners				Smoke, cigarette			
1	2	3	4	1	2	3	4	1	2	3	4
Heat, electric home				Paint, spray				Smoke, fireplace			
1	2	3	4	1	2	3	4	1	2	3	4
Heat, forced air				Paint, water-based				Smoke, cigar			
1	2	3	4	1	2	3	4	1	2	3	4
Heat, steam				Paint, oil-based				Soap			
1	2	3	4	1	2	3	4	1	2	3	4
Heating oil, home				Paint stripper				Soap, flea			
1	2	3	4	1	2	3	4	1	2	3	4
Herbicides (weed killer)				Paint thinner				Stain repellents			
1	2	3	4	1	2	3	4	1	2	3	4
Incense				Perfumes in cosmetics				Tape, surgical adhesive			
1	2	3	4	1	2	3	4	1	2	3	4
Inks, carbon paper				Perfumes/colognes				Tape. transparent			
1	2	3	4	1	2	3	4	1	2	3	4
Insecticide spray (bug killer)				Permanent hair wave solution				Tar containing soaps, ointments			
1	2	3	4	1	2	3	4	1	2	3	4
Insect repellent (personal use)				Pine scented products				Termite killers			
1	2	3	4	1	2	3	4	1	2	3	4
Kerosene				Plastic products(dentures, eye glasses)				Tile cleaners			
1	2	3	4	1	2	3	4	1	2	3	4
Kerosene exhaust				Pre-wash spot remover				Varnish, shellac. Lacquer			
1	2	3	4	1	2	3	4	1	2	3	4
Laundry bleach				Rubbing alcohol				Vinyl			
1	2	3	4	1	2	3	4	1	2	3	4
Laundry starch				Rugs, cotton				Vinyl asbestos. Linoleum tile			
1	2	3	4	1	2	3	4	1	2	3	4
Leather				Rugs, synthetic				Wall cleaner			
1	2	3	4	1	2	3	4	1	2	3	4

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Magazines				Rugs, musty old				Water, softened			
1	2	3	4	1	2	3	4	1	2	3	4
Marking pens				Rugs, wool				Water fluoridated			
1	2	3	4	1	2	3	4	1	2	3	4
Microware ovens				Rugs/carpeting, new				Window cleaner			
1	2	3	4	1	2	3	4	1	2	3	4
				Scouring pads				Wool garments			
				1	2	3	4	1	2	3	4

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