

The following questions can help you to understand if the symptoms a patient/client is experiencing may be attributable to environmental exposures from shale gas development (SGD).

**1. Do you currently live near any SGD facilities, such as the ones listed below? (Check all that apply)**

Well Pad	<input type="checkbox"/>	Impoundment Pond	<input type="checkbox"/>
Truck Traffic	<input type="checkbox"/>	Metering Station	<input type="checkbox"/>
Processing/Cryogenic/Fractionation Plant	<input type="checkbox"/>	Compressor Station	<input type="checkbox"/>
Pipeline	<input type="checkbox"/>	Pigging Station	<input type="checkbox"/>
Landfill accepting shale gas waste	<input type="checkbox"/>	Wastewater Treatment Plant (WWTP) accepting shale gas waste	<input type="checkbox"/>
Injection Well accepting shale gas waste	<input type="checkbox"/>	Petrochemical Plant	<input type="checkbox"/>

**2. Have there been incidents such as spills, leaks, or explosions that have occurred near your home, school, or place of work?    No    Yes    Unsure**

**3. Have you noticed a change in the taste, odor, or appearance in the water source at your home?    No    Yes**

**4. Have you noticed any unusual smells or changes in appearance in the air near your home?    No    Yes**

**5. Have you noticed any unusual dust, film, or residue on the outside of your home or car?    No    Yes**

**6. Have you experienced any of the following symptoms during or after activities near your home (that wouldn't necessarily be explained by an ongoing condition)? (Select all that apply)**

Sore or irritated throat	<input type="checkbox"/>	Sinus symptoms (runny nose/postnasal drip, etc.)	<input type="checkbox"/>
Cough or wheezing	<input type="checkbox"/>	Itchy/burning eyes	<input type="checkbox"/>
Itching of skin or rash	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	Abdominal pain/discomfort	<input type="checkbox"/>
Headache	<input type="checkbox"/>	Significant weight loss/gain	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	Nausea	<input type="checkbox"/>
Sleep disturbance	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	Irritability/mood swings	<input type="checkbox"/>
Other:	<input type="checkbox"/>	Other:	<input type="checkbox"/>

