

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"/>

- 7. Have you discussed symptoms you are having with any other doctors or health professionals previously? No Yes
- 8. Have you ever been diagnosed with any medical conditions? No Yes
If yes, please state: _____
- 9. Do you or anyone else in your household work onsite at a shale gas facility or in the transportation and processing of shale gas waste? No Yes

Additional Concerns or Notes



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