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SOUTHWEST PENNSYLVANIA ENVIRONMENTAL HEALTH PROJECT
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Individual Health Exposure Assessment

Adapted from ACMT and ATSDR

Instructions: It will be helpful if you answer the questions as best you can. Please don't worry if you can't answer everything, but give as much detail as you can remember. All information you give about your health is strictly confidential.

PLEASE PRINT

Last Name: First Name: Middle Name:				Date:
Street Address: City: State: Zip Code:				Home/Cell Phone: ( )
Date of Birth:	Age:	Marital Status (circle): Married Single Widow/Widower Divorced Partnered Separated	Gender:	Preferred language:
Name of Primary Care Provider:		Phone of Primary Care Provider: ( )		
Email Address:		Preferred method of contact:		
May we leave a message: Yes/No If yes, where:		May we add this information to the confidential registry? Yes / No		

I, (print your name) _____, voluntarily consent to the EHP's **exposure and health assessments**, possible **examination and/or testing** for myself that will be completed by the authorized consultants of EHP. I acknowledge that no guarantees have been made to me as to the outcome of my assessment or examination.
I have been given a copy of EHP's privacy policy.

Signature: _____ Date: _____

Witness: _____ Date: _____

(Print Name) (Signature)

Why are you here today? Do you have a current health concern? If so, please describe.

_____
_____
_____

Have you seen other health care providers for this concern? If so when, and what tests were ordered?

_____
_____
_____
_____

What symptoms have you had? Circle all symptoms you have had in the past year. Write the date the symptom started. Write "N" if this is a "new" symptom. Write a " W" if you have had the symptom for more than one year, but it got "worse" over the past year. Write "O" for "ongoing" if you still have the symptom. Write "R" if the symptom has gone away for "resolved". Add details to explain.

General Symptoms	**Date Started**	**New or Worse**	**Ongoing or Resolved**	**Give Details of Your Symptoms**
Weight loss				
Weight gain				
Weakness				
Fatigue				
Problems sleeping				
Dizziness				
Fever/chills				
Night sweats				
Other				
Skin Symptoms	**Date Started**	**New or Worse**	**Ongoing or Resolved**	**Give Details of Your Symptoms**
Skin rash				
Hives				
Blisters				
Skin irritation				
Itchiness or burning				
Skin cysts or growths				
Dry skin				
Other				
Eyes, Ears, Nose, Throat Symptoms	**Date Started**	**New or Worse**	**Ongoing or Resolved**	**Give Details of Your Symptoms**
Eye irritation				
Itchy eyes				
Burning eyes				
Vision problems/blurry/floaters				
Ringing in ears				

Participant's Name OR ID #_____

Hearing loss				
Decrease sense of smell				
Frequent runny nose/colds				
Frequent sinus problems				
Sore throat/throat irritation				
Nose bleeds				
Bleeding gums				
Mouth irritation				
Dry mouth				
Other				
Lung/Heart Symptoms	**Date Started**	**New or Worse**	**Ongoing or Resolved**	**Give Details of Your Symptoms**
Persistent/frequent cough				
Shortness of breath at rest				
Shortness of breath on exertion				
Wheezing				
Difficulty breathing				
Decreased exercise tolerance				
↑ heart rate				
↓ heart rate				
↑ blood pressure				
↓blood pressure				
Heart palpitations				
Heart flutter				
Chest pain				
Other				
Stomach/Bladder/Bowel Symptoms	**Date Started**	**New or Worse**	**Ongoing or Resolved**	**Give Details of Your Symptoms**
Nausea				
Vomiting				
Abdominal pain				
Heartburn or indigestion				
Loss of appetite				
Frequent diarrhea				
Constipation				
Blood in stools				
Blood in urine				
Problems with urination				
Other				
Reproductive/Endocrine System	**Date Started**	**New or Worse**	**Ongoing or Resolved**	**Give Details of Your Symptoms**
Infertility/Loss of pregnancy				
Period/menstrual issues				
Menopause issues				

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Children with birth defects				
Children with low birth weight				
Children with low APGAR scores				
Low testosterone				
Hair loss (not age related)				
↑ thirst				
↑ sweating				
Concerns about changes in sexual function				
Other				
Nerves/Muscle Symptoms	**Date Started**	**New or Worse**	**Ongoing or Resolved**	**Give Details of Your Symptoms**
Headaches—details				
Frequent falls				
Balance difficulties				
Tremors (shakes or twitches)				
Numbness and/or tingling				
Confusion or memory loss				
Concentration difficulties				
Problems speaking				
Muscle aches or cramps				
Painful joints				
Swollen joints				
Other				
Blood System Symptoms	**Date Started**	**New or Worse**	**Ongoing or Resolved**	**Give Details of Your Symptoms**
Bruise easily				
Prolonged bleeding				
Other				
Psychological/Stress Symptoms	**Date Started**	**New or Worse**	**Ongoing or Resolved**	**Give Details of Your Symptoms**
Unusual moodiness				
Unusual irritability				
Anxiety				
Panic attacks				
Depression				
Anger				
Stress				
Other				

Participant's Name OR ID #_____

Comments/Additional Information

_____
_____
_____
_____
_____
_____
_____

CURRENT PRESCRIPTION and NON-PRESCRIPTION MEDICATIONS, HERBS & SUPPLEMENTS

Name of prescription and non-prescription medications, herbs, and supplements	Dose	Times per Day	When Started	Reason for taking	Does it help relieve symptoms?

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

Medication/Food/Other Agent	Side Effect/Reaction

PAST MEDICAL HISTORY:

Please check (√) if you have ever been seen/treated by a healthcare provider for any of these conditions and give the date it started:

√	Condition	Date	√	Condition	Date
	Allergies/Hay Fever			Kidney disease	
	Bleeding problems			Liver disease	
	Cancer (type:)			Lung problems/TB	
	Depression			Metal poisoning	
	Diabetes			Multiple Chemical Sensitivity	
	Endocrine/Hormone(e.g., thyroid, low testosterone)			Neurological (e.g., tremor, stroke, blindness, seizures, coma, numbness, weakness, migraine)	
	Fibromyalgia			Psychological (e.g., depression, schizophrenia)	
	Hearing loss			Rash/skin issues	
	Heart disease			Valley Fever	
	High blood pressure			Other (Please specify)	

SURGICAL HISTORY List all surgical procedures and dates):

_____
_____

Participant's Name OR ID #_____

SOCIAL HISTORY: Check (√) all that apply

Smoking	**Never/On occasion**	**How many years?**	**Packs per day?**	**If quit, when?**	**Do you want to quit?**
Other Tobacco	**Never/On occasion**	**What type?**	**How often?**	**If quit, when?**	**Do you want to quit?**
Drinking	**Never/On occasion**	**How many per day?**	**What type?**	**If quit, when?**	**Do you want to quit?**

FAMILY HISTORY: Check (√) if your parents or siblings have a history of**:**

Medical Problem	**Check (√)**	**Parents or Siblings?**	**Medical Problem**	**Check (√)**	**Parents or Siblings?**	**Medical Problem**	**Check (√)**	**Parents or Siblings?**
Allergies			Thyroid Disease			Lung Problems/TB		
Bleeding problems or Blood diseases			Heart Disease			Rashes/Skin Problems		
Cancer – Type of Cancer:			High Blood Pressure			Neurological (tremor/stroke/seizures)		
Chemical Sensitivity			Kidney Disease			Psychological (depression/schizophrenia)		
Diabetes			Liver Disease			Other		

WORK HISTORY: Jobs with any potential exposures – Start with Most Recent

Date (from / to)	**Company / Type of Industry**	**Job Title**	**Any Exposure to Vapors, Gas, Dusts or Fumes (specify)**	**Protective Equipment Advised If so what type worn**

OTHER POSSIBLE EXPOSURE HISTORY: Check (√) if answer is "yes"

Do you wash work clothes at work?		Do you have a fireplace in your home? What type: _____How often do you use it?_____	
Do your wash work clothes at home?		When was your house or apartment built?	
Do you shower at work?		Has your home been tested for radon? If yes what were the results?	
Do you shower at home?		Has your home had problems with mold?	
Are you regularly exposed to second hand smoke?		Has your home been remodeled in last 6 months?	
Do you have a carbon monoxide detector in your home?		Have you had to move because of health problems?	
If you have a carbon monoxide detector in your home, has it alarmed recently?		Do your symptoms get worse at work?	
Have you traveled out of the country during the past year? If yes, where?		Do your symptoms get better when you are away from your home?	
Have you recently acquired new furniture or carpeting or refinished furniture?		Other	

Participant's Name OR ID #_____