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QUICK ENVIRONMENTAL HEALTH QUESTIONNAIRE *(Dr Ziem)*

Name _____ Date _____ Date of Birth _____ Age ___
Address _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

MEDICAL

1. Have you had a **burning-like feeling in eyes, nose, throat, lungs, other areas**: (circle) ❑ No ❑ Yes ❑ Unsure
   If yes, when did it first occur? _____
2. For each situation described below, answer the questions at the top of each column. By "sick", we mean anything **YOU** consider to be either a major or minor health problem. Put a check in the appropriate box.

	Would you be sick if you had to spend 4 hours ?					**Would you be sick if you had to spend 20 minutes ?**				
Exposures:	No	A Little	Moder-ately	A Lot	Don't Know	No	A Little	Moder-ately	A Lot	Don't Know
a. Next to person smoking cigarettes outside										
b. Driving in heavy traffic with windows open										
c. In a room sprayed with pesticides 4 hrs ago										
d. Next to person wearing cologne/ perfume										
e. Shopping in an enclosed mall										

Describe **a typical reaction** (if any), listing symptoms in order of onset, and describing the time frame. If your reactions are quite different from time to time, describe this also (put **None** if no reactions): _____

_____

_____

3. **For the symptoms and health problems listed below:** Circle the number that best describes how often the symptom occurs. **Also circle** specific symptoms when several are listed.

Daily/ Almost Daily	Several Times/ Week	Once A Week	Several Times/ Month	Once/ Month or Less	Rarely If Ever	Not Sure
Headache						
1	2	3	4	5	6	7
Confusion, spaciness, inability to concentrate **(circle)**						
1	2	3	4	5	6	7
Memory problems						
1	2	3	4	5	6	7
Sinus, nose, throat irritation/burning, ear congestion **(circle)**						
1	2	3	4	5	6	7

Daily/ Almost Daily	Several Times/ Week	Once A Week	Several Times/ Month	Once/ Month or Less	Rarely If Ever	Not Sure
Chest tightness, irritation or burning **(circle)**						
1	2	3	4	5	6	7
Fatigue (unusual)						
1	2	3	4	5	6	7
Bloating, gas, abdominal discomfort **(circle)**						
1	2	3	4	5	6	7
Insomnia						
1	2	3	4	5	6	7

****Questions 2 and 3 were assembled from a longer questionnaire used for research at Johns Hopkins U (A. Davidoff).***

4. **In the last year**, have you been : ❑ Much better ❑ A little better ❑ Same ❑ A little worse ❑ Much worse

5. **On most days, are you:**
   ❑ Fairly well, able to do all normal activities. ❑ Moderately ill, unable to do normal activities.
   ❑ Mildly ill, able to do most activities. ❑ Very ill, unable to do many activities.
   Describe what you do on a **fairly typical day**. _____

_____

_____

6. **Are your symptoms now worse at work, school or home?** ❑ No ❑ Yes **(circle location)** ❑ Not Sure
   IF YES: List symptoms that are worse there, and exposures you believe have affected you. Use extra paper if needed. _____

_____

_____

_____

8. Did you **leave your last work/school due to illness?** ❑ No ❑ Yes **If yes, when?**
If yes, discuss exposures, symptoms _____

_____

_____

9. Have you ever been around any of the following **frequently or in large amounts** in your work place, school or home?
IF YES:
a. Write the year(s) you were around it on the lines below:
b. Put an X by any that caused symptoms when exposed:

_____Adhesives, sealers	_____Copy machine	_____Solvents	_____Cleaning agents
_____Toxic waste site	_____Paints	_____Carbonless paper	_____New furniture
_____Exhaust fumes	_____Landfill	_____New carpet	_____Mold
_____Contaminated water	_____Pesticides	_____Solvents, thinners	_____Other (list type/dates)
_____Sick bldg/home	_____Lubricants	_____Cigarette smoke	

10. Home Environment:

Check below all that apply to your home	**Yes**	**No**	**Not Sure**
Pesticides used in home/on lawn			
Pesticides used in building			
Nearby lawn chemicals used			
Nearby traffic/vehicle exhaust			
Near busy road			
Nearby chimney/other smoke			
Windows hard to open			
Household carpet			
Damp basement			
Mold/mildew in your house			
Humidifier – standing water			
Symptoms w/family exposures			
Recent remodeling			
Recent pesticide use			
Gas furnace or fireplace (**circle**)			
Gas stove, dryer (**circle**)			
Gas water heater			
Fuel space heater (not electric)			
Wood stove/open fireplace			

Check all that apply to your bedroom	**Yes**	**No**
Carpet		
Candles		
Scented Items (more than a few)		
Plastic items (more than small amount)		
Particle Board Furniture		
Foam items (stuffed toys, etc)		
Books, Printed Matter (more than a few)		
Recent Synthetic Mattress		
Recent Foam/Synthetic Pillows		

Do you have hazardous products such as:

	Yes	**No**	**Not**
Electrostatic/ionizing filters			
Ozone generator			
"Air freshener" Products			
"Aromatherapy" Products			

Any other problems? _____

_____

11. Are you exposed to anything else of concern to you in your neighborhood or condo/apartment complex?
❑No ❑ Yes **If yes,** list _____

_____

_____

_____

12. Do you have a nearby non-toxic outdoor area, such as a large park or other wooded area, where you can walk without an increase in your symptoms? ❑ No ❑ Yes ❑ Not Sure
13. How many hours a week, on average, are you outside in a non-toxic area? ___hours

If you have illness/concerns about the above issues, consider the book Less Toxic Alternatives by health educator Carolyn Gorman (800-428-2343).