Exposure History Form

Part 1. Exposure Survey

Please circle the appropriate answer.

Name: _____ **Date:** _____

Birth date: _____ **Sex (circle one):** Male Female

1. Are you currently exposed to any of the following?

metals	no	yes
dust or fibers	no	yes
chemicals	no	yes
fumes	no	yes
radiation	no	yes
biologic agents	no	yes
loud noise, vibration, extreme heat or cold	no	yes

2. Have you been exposed to any of the above in the past? no yes

3. Do any household members have contact with metals, dust, fibers, chemicals, fumes, radiation, or biologic agents? no yes

If you answered *yes* to any of the items above, describe your exposure in detail—how you were exposed, to what you were exposed. If you need more space, please use a separate sheet of paper.

4. Do you know the names of the metals, dusts, fibers, chemicals, fumes, or radiation that you are/were exposed to? no yes

5. Do you get the material on your skin or clothing? no yes

6. Are your work clothes laundered at home? no yes

7. Do you shower at work? no yes

8. Can you smell the chemical or material you are working with? no yes

9. Do you use protective equipment such as gloves, masks, respirator, or hearing protectors? no yes

10. Have you been advised to use protective equipment? no yes

11. Have you been instructed in the use of protective equipment? no yes

If *yes*, list them below

If *yes*, list the protective equipment used

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12. Do you wash your hands with solvents?	no	yes			
13. Do you smoke at the workplace?	no	yes	At home?	no	yes
14. Are you exposed to secondhand tobacco smoke at the workplace?	no	yes	At home?	no	yes
15. Do you eat at the workplace?	no	yes			
16. Do you know of any co-workers experiencing similar or unusual symptoms?	no	yes			
17. Are family members experiencing similar or unusual symptoms?	no	yes			
18. Has there been a change in the health or behavior of family pets?	no	yes			
19. Do your symptoms seem to be aggravated by a specific activity?	no	yes			
20. Do your symptoms get either worse or better at work?	no	yes			
at home?	no	yes			
on weekends?	no	yes			
on vacation?	no	yes			
21. Has anything about your job changed in recent months (such as duties, procedures, overtime)?	no	yes			
22. Do you use any traditional or alternative medicines?	no	yes			

If you answered *yes* to any of the questions, please explain.

Part 2. Work History

Name: _____

A. Occupational Profile

Birth date: _____ **Sex:** Male Female

The following questions refer to your current or most recent job:

Job title: _____ Describe this job: _____

Type of industry: _____ _____

Name of employer: _____ _____

Date job began: _____ _____

Are you still working in this job? yes no _____

If *no*, when did this job end? _____ _____

Fill in the table below listing all jobs you have worked including short-term, seasonal, part-time employment, and military service. Begin with your most recent job. Use additional paper if necessary.

Dates of Employment	Job Title and Description of Work	Exposures*	Protective Equipment

*List the chemicals, dusts, fibers, fumes, radiation, biologic agents (i.e., molds or viruses) and physical agents (i.e., extreme heat, cold, vibration, or noise) that you were exposed to at this job.

Have you ever worked at a job or hobby in which you came in contact with any of the following by breathing, touching, or ingesting (swallowing)? If *yes*, please check the box beside the name.

- ○ Acids
- ○ Alcohols (industrial)
- ○ Alkalies
- ○ Ammonia
- ○ Arsenic
- ○ Asbestos
- ○ Benzene
- ○ Beryllium
- ○ Cadmium
- ○ Carbon tetrachloride
- ○ Chlorinated naphthalenes
- ○ Chloroform
- ○ Chloroprene
- ○ Chromates
- ○ Coal dust
- ○ Dichlorobenzene
- ○ Ethylene dibromide
- ○ Ethylene dichloride
- ○ Fiberglass
- ○ Halothane
- ○ Isocyanates
- ○ Ketones
- ○ Lead
- ○ Mercury
- ○ Methylene chloride
- ○ Nickel
- ○ PBBs
- ○ PCBs
- ○ Perchloroethylene
- ○ Pesticides
- ○ Phenol
- ○ Phosgene
- ○ Radiation
- ○ Rock dust
- ○ Silica powder
- ○ Solvents
- ○ Styrene
- ○ Talc
- ○ Toluene
- ○ TDI or MDI
- ○ Trichloroethylene
- ○ Trinitrotoluene
- ○ Vinyl chloride
- ○ Welding fumes
- ○ X-rays
- ○ Other (specify)

B. Occupational Exposure Inventory

Please circle the appropriate answer.

1. Have you ever been off work for more than 1 day because of an illness related to work? no yes
2. Have you ever been advised to change jobs or work assignments because of any health problems or injuries? no yes
3. Has your work routine changed recently? no yes
4. Is there poor ventilation in your workplace? no yes

Part 3. Environmental History

Please circle the appropriate answer.

1. Do you live next to or near an industrial plant, commercial business, dump site, or nonresidential property? no yes
2. Which of the following do you have in your home?
   Please circle those that apply.
   Air conditioner Air purifier Central heating (gas or oil?) Gas stove Electric stove
   Fireplace Wood stove Humidifier
3. Have you recently acquired new furniture or carpet, refinished furniture, or remodeled your home? no yes
4. Have you weatherized your home recently? no yes
5. Are pesticides or herbicides (bug or weed killers; flea and tick sprays, collars, powders, or shampoos) used in your home or garden, or on pets? no yes
6. Do you (or any household member) have a hobby or craft? no yes
7. Do you work on your car? no yes
8. Have you ever changed your residence because of a health problem? no yes
9. Does your drinking water come from a private well, city water supply, or grocery store?
10. Approximately what year was your home built?_____

If you answered *yes* to any of the questions, please explain.