

# Exposure History Form

**Part 1. Exposure Survey**

**Name:**

**Date:**

*Please select the appropriate answer.*

**Birth date:**

**Sex (select 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, how much, how often, and how long you were exposed?

<p>4. Do you know the names of the metals, dusts, fibers, chemicals, fumes, or radiation that you are/were exposed to?</p> <p style="text-align: right;">no    yes</p>	<p>If yes, list them below</p>
<p>5. Do you get the material on your skin or clothing?</p> <p style="text-align: right;">no    yes</p>	
<p>6. Are your work clothes laundered at home?</p> <p style="text-align: right;">no    yes</p>	
<p>7. Do you shower at work?</p> <p style="text-align: right;">no    yes</p>	
<p>8. Can you smell the chemical or material you are working with?</p> <p style="text-align: right;">no    yes</p>	
<p>9. Do you use protective equipment such as gloves, masks, respirator, or hearing protectors?</p> <p style="text-align: right;">no    yes</p>	<p>If yes, list the protective equipment used</p>
<p>10. Have you been advised to use protective equipment?</p> <p style="text-align: right;">no    yes</p>	
<p>11. Have you been instructed in the use of protective equipment?</p> <p style="text-align: right;">no    yes</p>	

- |  |    |     |
|--|----|-----|
| 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 (such as herbs or natural supplements) alternative medicines?                 | no | yes |
| 23. Have you or your child ever eaten non-food items such as paint, plaster, dirt and/or clay?   | no | yes |

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

**Part 2. Work History**

**A. Occupational Profile**

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

Job title:

Type of industry:

Name of employer:

Date job began:

Are you still working in this job?    yes            no

If *no*, date job ended?

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.

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 select beside the name.

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

**B. Occupational Exposure Inventory***Please select 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 select 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?<br><i>Please select those that apply.</i>   |    |     |
| Air conditioner      Air purifier      Central heating ( Gas   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?   | no | yes |
|   | no | yes |
|   | no | yes |
|   | no | yes |
| 10. Approximately what year was your home built?  |    |     |
| 11. Does your food come from somewhere other than a grocery store?  | no | yes |

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