Exposure Screening Questionnaire

(Make this screening questionnaire part of your intake assessment or have each patient complete it at home.)

Occupational Profile

Name: ____

Birth Date: ______________________________ Sex (circle one): Male / Female

Today's Date: ______________________________

Current Job Title/Occupation: ____

Industry: ____

Circle the appropriate answer.

1. Are you currently exposed to any of the following?		
Metals	No	Yes
Dust or fibres	No	Yes
Chemicals	No	Yes
Fumes, vapours, gases	No	Yes
Radiation	No	Yes
Loud noise, vibration, extreme heat or cold	No	Yes
Biological agents (e.g. moulds, viruses)	No	Yes
2. Have you been exposed to any of the above in the past? *(If yes, please list them.)*	No	Yes
3. Do any household members have contact with metals, dust, fibres, chemicals, fumes, radiation, or biologic agents?	No	Yes
4. Do you know the names of the metals, dusts, fibres, chemicals, or fumes that you are/were exposed to? (*If yes, please list them.*)	No	Yes
5. Do you feel any aspect of your health is aggravated by work? *(If yes, how?)*	No	Yes
6. Are you aware of similar health concerns with any of your co-workers?	No	Yes

If you need more space, please use the back of the questionnaire.