Detailed Exposure History

Name: _____

Birth Date: _____ Sex (*circle one*): Male / Female

Today's Date: _____

A: Occupational Profile

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

Job title: _____

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? _____

If yes, what is your present employee status (*circle all that apply*):

Full-time Part-time Shift Work Modified Duties Regular Duties

Please fill in the table below listing all the jobs you have ever worked including short-term, seasonal, part-time employment, and any military service.

Name: _____

The next page lists agents to assist you in recalling specific exposures. Please do not rely on this guide alone, as there may be other chemicals or materials to which you were exposed that are as important as those listed. List ALL agents you were (and are) exposed to both directly and indirectly.

(Begin with your most recent job. Use additional paper if necessary.)

Date of Employment	Employer/Contractor and Site of Work	Job Title and Description of Work (Major Tasks)	Known Exposures*	Amount of Exposure (Hours/Day & Days/Week)	Protective Equipment (PPE) Used

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

Name: _____

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)? (*Circle all that apply*)

Acids or acid mists	Chromates	Lead	Solvents
Alcohols	Coal dust	Mercury	Styrene
Alkalies	Coal tars, asphalt, roofing tars, creosote, coke oven emissions	Metals (other – specify) _____	Talc
Ammonia	Dichlorobenzene	Methylene chloride	Toluene
Arsenic	Dust (specify) _____	Nickel	TDI or MDI
Asbestos	Ethylene dibromide	PBBs	Trichloroethylene
Benzene	Ethylene dichloride	PCBs	Trinitrotoluene
Beryllium	Fibreglass	Perchloroethylene	Vinyl chloride
Cadmium	Formaldehyde	Pesticides	Welding fumes
Carbon tetrachloride	Gasoline	Phenol	X-rays
Chlorinated naphthalenes	Halothane	Phosgene	Other (specify) _____
Chloroform	Isocyanates	Radiation	_____
Chloroprene	Ketones	Silica	

Name: _____

B. Occupational Exposure History

(Circle the appropriate answer.)

1. Have you ever been off work for more then 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. Is personal protective equipment (PPE) worn? (*If yes, circle all that apply*) Coveralls, Respiratory, Glove, Safety Glasses, Hearing Protection, Safety Shoes, Mask)	No	Yes
4. Is there poor ventilation in your workplace?	No	Yes
5. Do you smell the chemical or material you are working with?	No	Yes
6. Do you get material on your skin or clothing?	No	Yes
7. Are your work clothes laundered at home?	No	Yes
8. Do you shower at work?	No	Yes
9. Do your symptoms get better or worse at work?	Better	Worse
At home?	Better	Worse
On weekends?	Better	Worse

Name: _____

C. Environmental History

(Circle the appropriate answer.)

1. Do you live next to or near an industrial plant (e.g. smelter, quarry), commercial business (e.g. dry cleaners), dump site, or non-residential property (e.g. airport, golf course)?	No	Yes
2. Do you live within 1.6 km (1 mile) from high voltage power lines?	No	Yes
3. Which of the following do you have in your home? *(Circle all that apply.)*		
Air conditioner / Gas Stove		
Central Heating (gas or oil?) / Fireplace		
Electric stove / Humidifier		
Home carpentry shop or cut / store wood		
4. Have you recently acquired new furniture or carpets, refinished furniture, or remodelled your home?	No	Yes
5. Have you recently weather-proofed your home?	No	Yes
6. Are pesticides or herbicides (insect or weed killers; flea and tick sprays, collars, powders, or shampoos) used in your home or garden, or on pets?	No	Yes
7. Do you (or any household member) have a hobby or craft? (e.g. art, refinishing, auto repair, welding, photography, etc.)	No	Yes
8. Do you work on your car?	No	Yes
9. Do you have a garage attached to your house?	No	Yes
10. Have you ever changed your residence because of a health problem?	No	Yes
11. Does anyone in your household have environmental allergies (e.g. hay fever)?	No	Yes
12. Does your drinking water come from (*circle answer)*: a private well, city water supply, or grocery store?		
13. Approximately what year was your home built? _____		

(If you answered yes to any of the above questions, please explain.)

Name: _____

D. Personal / Lifestyle History

1. Do you smoke?	No	Yes
2. Are you exposed to second-hand tobacco smoke		
at the workplace?	No	Yes
at home?	No	Yes
3. Do you drink alcohol? (# of drinks per week on average _____)	No	Yes
4. Do you exercise regularly? (minimum 30 minutes, 3-4 times a week)	No	Yes
5. Are family members experiencing similar or unusual symptoms?	No	Yes
6. Do you use traditional or alternative medicines?	No	Yes
7. Do you have any of the following conditions? (C*ircle all that apply*)		
Shortness of breath, phlegm, asthma, emphysema, lung cancer, Chronic Obstructive Pulmonary Disease (COPD)	No	Yes
Any other? _____		
8. When was your last chest x-ray? _____		
9. How often has your residence been tested for pests? _____		
10. Have you or anyone in your family (e.g. mother or siblings) had a miscarriage or birth defects?	No	Yes

(If you answered yes to any of the above questions, please explain.)

Adapted from:
Exposure History Form. Agency for Toxic Substances & Disease Registry (ATSDR). Available at: http://www.atsdr.cdc.gov/csem/exphistory/ehexposure_form.html