WOMEN'S COLLEGE HOSPITAL
Health care for women REVOLUTIONIZED

Environmental Health Clinic

Tel: 1-800-417-7092 • (416) 351-3764
Fax: (416) 323-6130

Thank you for your interest in the Environmental Health Clinic.
In this link you will find:

- **Dear Patient Letter:** we are a **scent-free** environment,
- **Dear Patient Letter:** registry of knowledgeable sensitive physicians
- **Patient Consent for E-Mail Communications**
- **Pre-Visit Questionnaire:** please provide your identification on each page.

Please complete the Pre-Visit Questionnaire and Patient Consent for E-Mail Communications (if you use e-mail) and return to the Environmental Health Clinic as soon as possible. You will be placed in the queue to be seen at the clinic from the date we receive the completed questionnaire. Our Admin Assistant will contact you to arrange an appointment 4 – 6 weeks prior to your Environmental Health Clinic visit.

If you have questions about clinic procedures or the information we are sending you, please phone our main clinic number (416) 351-3764 or 1-800-417-7092.

Sincerely,

Environmental Health Clinic

Mailing Address:
Women's College Hospital
76 Grenville Street
Toronto, ON
M5S 1B6
Attn: Environmental Health Clinic

WCH

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Dear Patient:

The Environmental Health Clinic is a **scent-free environment**.

To protect patients and staff, it is important that you and your visitors do not use scented personal care products such as scented soaps, shampoos, mousse, and hairsprays, along with perfumes, aftershaves, and colognes, prior to your visit.

To remove any residual perfume or smoke odours from the clothing you will be wearing to your clinic appointment, please wash this clothing in a scent-free detergent and dry with no fabric softeners.

Prior to entering the clinic, a staff person will wish to meet with you outside the clinic door, to screen you to ensure that you and your visitors do not have any scents that could contaminate the clinic's environment.

If you do screen positive for scents, then we **may not** be able to see you at your scheduled appointment.

If you would like further information on scent-free products, visit www.lesstoxicguide.ca.

Thank you for helping to keep the Environmental Health Clinic a safe place for people with sensitivities to scented products.

WCH

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Dear Patient:

The Environmental Health Clinic is asking for your assistance.

We are compiling a registry of family physicians and/or specialists who are knowledgeable and sensitive to patients with environmental health problems, for example Environmental Sensitivities/Intolerances, Fibromyalgia, Chronic Fatigue Syndrome.

Are there any family physicians/specialists that you recommend that we add to our registry?

Family Physician Name: ______________________________

Address: ______________________________

____

Telephone: ______________________________

Fax: ______________________________

Specialist Physician Name: ______________________________

Specialty (such as endocrinologist, gastroenterologist,
allergist/immunologist,
rheumatologist, gynecologist, neurologist, psychiatrist, etc.): ______________________________

Address: ______________________________

____

Telephone: ______________________________

Fax: ______________________________

Please use additional paper if necessary, and please return this form with your completed Intake Questionnaire.

PATIENT CONSENT FOR E-MAIL COMMUNICATIONS

PATIENT IDENTIFICATION

Dear Patient:

Your care provider may communicate with you or others using e-mail, at their discretion. However, you should know that these e-mail messages are not encrypted, may exist indefinitely and that the hospital cannot guarantee the security of messages sent outside the hospital email system. For this reason, e-mail should not be used to communicate certain sensitive types of information which might be harmful to you if read by an unintended recipient. You may also have other types of information that you would prefer not to have discussed in e-mail messages, which you should inform your care provider about. Do not use e-mail to communicate emergency or urgent health matters. Go to the nearest emergency department if you have an emergency.

If you have not received a response to your e-mail within an expected time period it is your responsibility to telephone your care provider. You should not expect a response before one business day.

The clinically relevant content of the e-mail message will be filed in your medical record. Each individual care provider has the authority to decide whether to email and reserves the right to cease email communication at any time, in which case you will be notified. By signing this consent form, you acknowledge that you have read and agree with these terms. If you have questions about e-mail communications with your care providers at Women's College Hospital, please contact your care provider and/or the WCH Privacy Officer 416-323-6096. You may at any time withdraw your consent for e-mail communication by notifying your care provider and should document this consent withdrawal on this form.

I consent and agree to:

O Communicate with my care team using e-mail

O My care team communicating with ____________________ using e-mail
(Names of Other Care Providers)

My email address is : ____________________

Date: / /
YYYY/MM/DD

____
Signature of Patient/Substitute Decision Maker

____
If Substitute Decision Maker, state relationship

Withdrawal of Consent for E-mail Communication:
I no longer consent to communication via e-mail.

Date: / /
YYYY/MM/DD

____
Signature of Patient/Substitute Decision Maker

____
If Substitute Decision Maker, state relationship

Disclaimer: On-call physicians and those covering patient care for other physicians are not obligated to use e: mail communication with those patients.

ENVIRONMENTAL HEALTH CLINIC
Pre-Visit Questionnaire

The information you provide on this form may be shared with your family doctor and other physicians involved in your care, and, on request, with third parties (e.g. insurance companies or lawyers etc.) to whom you have given consent for release of your medical information. Your medical record including this form may also be subjected to legal subpoena.

FOR OFFICE USE ONLY

Date Sent: ______________ Date Received: ______________

Date of Consultation: ______________ Chart Number: ______________

Start Time: ______________ Stop Time: ______________

PATIENT INFORMATION *(please print)*

Name: ______________ ______________ ______________
Last *First* *Middle*

Health Card Number: ______ - ______ - ______ ______ **Preferred Name to Call You:** ______________

Address: ______________
Street *Apt. #*

______________ ______________ ______________
City / Town *Province* *Postal Code*

Phone: Home (____) ____ – ______ Work (____) ____ – ______ Cell (____) ____ – ______

May we leave messages for you at WORK ☐ No ☐ Yes, HOME ☐ No ☐ Yes, FAX ☐ No ☐ Yes, EMAIL ☐ No ☐ Yes

Fax: (____) ____ – ______ **Email:** ______________ **Sex:** ☐ M ☐ F

Age: ______ **Date of Birth:** ______ / ______ / ______ **Place of Birth:** ______________
year *month* *day* *Country* *Province/State* *City/Town*

Do you have: ☐ drug plan ☐ dental plan ☐ extended benefits plan **Insurance Company:** ______________

Are you receiving benefits: ☐ short-term disability ☐ long-term disability ☐ CPP ☐ ODSP ☐ WSIB

Do you currently have any unresolved legal matters? ☐ No ☐ Yes **If yes, please specify:** ______________

REFERRING DOCTOR

Name: ______________

Address: ______________
Street *Suite #*

______________ ______________ ______________
City / Town *Province* *Postal Code*

Telephone: (____) ____ – ______ **Fax:** (____) ____ – ______

FAMILY DOCTOR

☐ **Same as above** ☐ **I do not have a family doctor.**

Name: ______________

Address: ______________
Street *Suite #*

______________ ______________ ______________
City / Town *Province* *Postal Code*

Telephone: (____) ____ – ______ **Fax:** (____) ____ – ______

How did you hear about this clinic? ______________

How do you hope we may be able to help you? ______________

____

____

MAIN SYMPTOM(S) THAT BRING YOU TO THIS CLINIC AND DATE(S) WHEN FIRST BEGAN:

Date when you last felt consistently well:

STORY OF MAIN SYMPTOM(S)

Please tell us your story of the **main symptoms** that bring you to the Environmental Health Clinic:

- from the ***beginning*** up ***to now***
- any ***times*** or ***places*** symptom(s) ***worse*** or ***better***
- ***anything*** you have ***noticed made*** symptom(s) ***worse*** or ***better***
- any ***diagnoses*** you have been given and ***by whom***

BEGINNING OF MAIN SYMPTOMS

Do you remember any events or illnesses that may have contributed to the beginning of your main symptoms?
[please check all boxes that apply, specify as requested and write date(s) as closely as you can remember]

	Date(s)	How much contribution do you think each event or illness made to the beginning of your main symptoms? *(Please circle one number for each.)*					
		None	A little	Some	Moderate	Strong	Don't know
❑ virus, bacterial or parasite infection ➡ *type:*________	________	0	1	2	3	4	5
❑ use of antibiotics ➡ *antibiotic name:*________	________	0	1	2	3	4	5
❑ serious illness, not infection ➡ *type:*________	________	0	1	2	3	4	5
❑ dental problems – fillings, root canals, dentures ➡ *specify:*________	________	0	1	2	3	4	5
❑ surgery ➡ *type:*________	________	0	1	2	3	4	5
❑ injury / accident ➡ *type:*________	________	0	1	2	3	4	5
❑ pregnancy / childbirth	________	0	1	2	3	4	5
❑ menopause	________	0	1	2	3	4	5
❑ start or change of medication / vaccination ➡ *medication name:*________	________	0	1	2	3	4	5
❑ blood transfusion	________	0	1	2	3	4	5
❑ alcohol or drug abuse	________	0	1	2	3	4	5
❑ family problems ➡ *specify:*________	________	0	1	2	3	4	5
❑ loss or illness of someone close to you ➡ *specify:*________	________	0	1	2	3	4	5
❑ change in marital status ➡ *specify:*________	________	0	1	2	3	4	5
❑ financial set-back	________	0	1	2	3	4	5
❑ emotional problems ➡ *specify:*________	________	0	1	2	3	4	5
❑ physical, emotional or sexual abuse issues	________	0	1	2	3	4	5
❑ change in place of residence ➡ *(location) from* ________ *to* ________	________	0	1	2	3	4	5
❑ renovation(s) at home ➡ *specify:* ________	________	0	1	2	3	4	5
❑ chemical / toxic exposure ○ pesticides ○ solvents ○ other as an adult ➡ *specify:*________	________	0	1	2	3	4	5
❑ chemical / toxic exposure ○ pesticides ○ solvents ○ other in childhood ➡ *specify:*________	________	0	1	2	3	4	5
❑ change in workplace ➡ *(location) from* ________ *to* ________	________	0	1	2	3	4	5
❑ renovation(s) at work ➡ *specify:*________	________	0	1	2	3	4	5
❑ change in job ➡ *(description) from* ________ *to* ________	________	0	1	2	3	4	5
➡ *if stopped working, please specify date last worked*	________						
❑ other events / illnesses *(please specify)*							
________	________	0	1	2	3	4	5
________	________	0	1	2	3	4	5
________	________	0	1	2	3	4	5
________	________	0	1	2	3	4	5
________	________	0	1	2	3	4	5

Health History Summary
From Birth to Present

Please summarize, in order from birth to present, using additional paper if necessary: ALL SURGERIES, HOSPITALIZATIONS, SERIOUS, RECURRENT, OR CHRONIC ILLNESSES, INJURIES you have had. If females, include any PREGNANCIES and ANY COMPLICATIONS.

Age *(start at birth)*	Year *(approx.)*	Summary of Health Problems *List surgeries, hospitalizations, serious, recurrent, or chronic illnesses, injuries (e.g. pneumonia, TB, ulcer, gall bladder trouble, hepatitis, etc.)*	For Office Use ONLY

Help for Health Problems

What have you found MOST helpful for your present health problem(s)?

____

____

How many visits have you had to your continuing care family physician in the last 12 months? ____________

What other doctors have you seen besides your continuing care family physician? *(please check all that apply)*

✓	Type of Physician	Name	Reason(s) seen	When *specify year(s)*	No. of Visits in last 12 months
	Allergist / Immunologist				
	Cardiologist *(Heart)*				
	Dermatologist *(Skin)*				
	Endocrinologist *(Gland)*				
	Environmental Physician				
	Gastroenterologist *(Stomach / Bowel)*				
	General Surgeon				
	Gynecologist				
	Hematologist *(Blood)*				
	Neurologist				
	Occupational Physician				
	Ophthalmologist *(Eye)*				
	Orthopaedic Specialist *(Bone)*				
	Otolaryngologist *(Ear, Nose, Throat)*				
	Physiatrist *(rehab)*				
	Psychiatrist				
	Respirologist *(Lung)*				
	Rheumatologist *(Joint / Muscle)*				
	Other(s) *(please specify)*				

What other health care professionals / providers have you seen? *(please check all that apply)*

✓	Type of Health Care Provider	Name	Reason(s) seen	When *specify year(s)*	No. of Visits in last 12 months
	Acupuncturist				
	Chiropractor				
	Dentist				
	Dental Hygienist				
	Dietitian				
	Herbalist				
	Homeopath				
	Massage Therapist				
	Naturopath				
	Nutritionist				
	Occupational Therapist				
	Optometrist				
	Physiotherapist				
	Psychologist				
	Public Health Nurse				
	Respiratory Therapist				
	Social Worker				
	Other(s) *(please specify)*				

Body Systems Survey

In general, how has your health been in the last 12 months?

☐ excellent ☐ very good ☐ good ☐ satisfactory ☐ fair ☐ poor ☐ extremely poor

Have you had any of the following symptoms <u>in the last 12 months</u>? *(please check all that apply)*

1. Constitutional and Endocrine (Glandular) Symptoms

☐ night sweating ➞ How often? ______________

☐ excessive daytime sweating ➞ Triggers? ______________

☐ unexplained body odour

☐ feeling cold ➞ How often? ______________

☐ cold hands / cold feet ➞ How often? ______________

☐ fever ➞ Degree (*in* °C / °F) ________ ➞ How often? ______________

☐ significant weight gain ➞ When? ______________
How many *pounds* or *kilograms*? ______________ In how long? ______________

☐ significant weight loss ➞ When? ______________
How many *pounds* or *kilograms*? ______________ In how long? ______________

If normal energy is "9 – 10," in the last 12 months, on average, what energy have you had?

On a good day? _______ / 10 ➞ Number of good days / week ______________

On a bad day? _______ /10 ➞ Number of bad days / week ______________

On average, how tired have you felt (in the last 12 months) compared to when you were last consistently well?

☐ no difference ☐ a little more tired ☐ somewhat more tired ☐ a lot more tired

Is your tiredness relieved by rest? ☐ No ☐ Yes ➞ If yes, ○ always ○ sometimes

On average, how much is your tiredness relieved?
○ a little ○ some ○ a lot ○ completely

In the last 12 months, how many hours per day of useable energy have you had on average (i.e. able to do activities)?

On a good day ➞ Number of hours: ______________

On a bad day ➞ Number of hours: ______________

In the past 12 months, on average how many days a week have you spent most of the time in bed unable to do activities? ________

In the past 12 months, on average how many days a week are you unable to socialize due to symptoms? _______

2. Nervous System Symptoms

*(if you have noticed anything **triggers** your symptoms or **helps** relieve them, please specify)*

	Triggers	Helpers
☐ migraine ➞ How often? __________ Location: ______________		
Associated vision changes? ➞ ○ No ○ Yes *(please specify)* ______________		
☐ other headaches ➞ How often? __________ Location: ______________		
Type *(please specify)* ______________		
☐ epileptic seizures		
☐ bumping into things, clumsiness, unsteadiness on feet		
☐ lightheadedness		
☐ dizziness (spinning)		
☐ unexplained falls		
☐ "pins and needles" feelings		

↳ *see next page*

2. Nervous System Symptoms *[continued]*

(if you have noticed anything triggers your symptoms or helps relieve them, please specify)

Symptoms	Triggers	Helpers
❑ dull, groggy		
❑ spacey		
❑ difficulty concentrating		
❑ trouble finding words		
❑ forgetfulness of recent events		
❑ difficulty learning new information		
❑ anxiety, tension		
❑ excessive fears		
❑ panic attack(s)		
❑ difficulty sitting still, restlessness		
❑ mood swings		
❑ Depression ➞ Please rate on average from 1=very mild to 10=suicidal *(circle one)* 1 · 2 · 3 · 4 · 5 · 6 · 7 · 8 · 9 · 10		
❑ feeling excessive guilt		
❑ loss of interest		
❑ hopelessness		
❑ feelings of harming yourself		
❑ increased irritability		
❑ tendency to excessive anger		
❑ Sleep Problems: ○ sleeping more than usual ○ sleeping less than usual ➞ average number of hours slept per night ______ ➞ average number of hours slept in 24 hours______ ○ problems getting to sleep ○ interrupted sleep / problems staying asleep ○ snoring ○ nightmares ○ wakening unrefreshed ○ jerking of limbs		
❑ other(s) *(please specify)* ________________		

3. Eyes, Ears, Nose, Throat

(if you have noticed anything triggers your symptoms or helps relieve them, please specify)

	Symptoms	Triggers	Helpers
① Eyes	❑ dark circles		
	❑ itchy		
	❑ burning, watering		
	❑ sticky, discharging		
	❑ redness		
	❑ difficulty focusing / blurred vision		
	❑ loss of vision		
	❑ eye pain		
	❑ swelling of eyelid(s)		
	❑ sensitivity to light		
	❑ other(s) *(please specify)*__________		

Have you had any of the following symptoms <u>in the last 12 months</u>? *(please check all that apply)*

3. Eyes, Ears, Nose, Throat *[continued]*

(if you have noticed anything triggers your symptoms or helps relieve them, please specify)

	Symptoms	Triggers	Helpers
② Ears	☐ itchy		
	☐ infection ➡ when? ______		
	☐ fluid leaking		
	☐ full or blocked sensations in ear(s)		
	☐ decreased hearing		
	☐ ringing (tinnitus)		
	☐ sensitivity to noise		
	☐ other(s) *(please specify)* ______		
③ Nose	☐ itchy		
	☐ burning		
	☐ sneezing, running, congested, postnasal drip without a cold		
	☐ bleeding		
	☐ sinus fullness or stuffiness		
	☐ sinus pain or discharge		
	☐ upper respiratory infection (cold) ➡ number of months (in last 12 months) you had a cold ______ ➡ average duration ______		
	☐ stronger sense of smell than the average person		
	☐ smells are sickening ➡ please specify which smell(s) ______		
	☐ other(s) *(please specify)* ______		
④ Mouth, Throat	☐ cold sores		
	☐ itchy		
	☐ cankers		
	☐ bad or metallic taste		
	☐ coated tongue		
	☐ gum problems		
	☐ dental or denture problems ➡ specify: ______		
	☐ root canals ➡ Number: ______ ➡ Problems: ______		
	☐ unexplained bad breath		
	☐ sore throat		
	☐ hoarseness or loss of voice		
	☐ other(s) *(please specify)* ______		

↪ *see next page*

Have you had any of the following symptoms in the last 12 months? *(please check all that apply)*

4. Lungs *(if you have noticed anything triggers your symptoms or helps relieve them, please specify)*

Symptoms	Triggers	Helpers
❑ cough		
❑ phlegm		
❑ tight chest		
❑ wheezing		
❑ shortness of breath		
❑ other(s) *(please specify)* ______		

5. Heart and Circulation *(if you have noticed anything triggers your symptoms or helps relieve them, please specify)*

Symptoms	Triggers	Helpers
❑ unexplained fast heartbeat		
❑ irregular heart beat		
❑ palpitations (heart pounding)		
❑ chest pressure / pain		
❑ heart murmur *(please specify)* ______		
❑ blood pressure problem *(please specify)* ______		
❑ unusual flushing		
❑ colour changes in fingers		
❑ easy bruising		
❑ bleeding tendency		
❑ varicose veins		
❑ other(s) *(please specify)* ______		

6. Gastrointestinal (stomach and bowel)

(if you have noticed anything triggers your symptoms or helps relieve them, please specify)

Symptoms	Triggers	Helpers
❑ appetite change → ○ increase ○ decrease		
❑ nausea		
❑ burping / belching		
❑ heartburn		
❑ upper abdominal pain		
❑ gall bladder problem		
❑ yellow jaundice		
❑ bloating		
❑ flatulence (excess gas)		
❑ lower abdominal pain / discomfort		
❑ constipation		
❑ diarrhea		
❑ mucous in stools		
❑ black tarry stools		
❑ blood in stools		
❑ rectal itching / burning		
❑ incontinence of stool		
❑ hernia *(specify type)* ______		
❑ other(s) *(please specify)* ______		

Have you had any of the following symptoms in the last 12 months? *(please check all that apply)*

7. Genitourinary *(if you have noticed anything triggers your symptoms or helps relieve them, please specify)*

Symptoms	Triggers	Helpers
❑ bladder infection → number of infections in last 12 months ______		
❑ passing your urine more frequently		
❑ pain / discomfort when or after passing urine		
❑ discomfort in lower abdomen associated with urination		
❑ getting up at night to pass your urine → How many times a night?______		
❑ feeling as if bladder is not totally empty after voiding		
❑ leaking urine (e.g. when coughing or laughing)		
❑ decreased sex drive		
❑ sexually transmitted disease → if you ever had it, please specify the type(s) and year(s) ______		
Have you ever had test(s) for HIV? ❑ No ❑ Yes → result(s) and the year(s) ______		
❑ other(s) *(please specify)* ______		
① **For Men Only**		
❑ problems starting flow of urine		
❑ slower flow of urine		
❑ discharge from penis		
❑ trouble getting or sustaining an erection		
❑ discomfort in testicles or base of penis		
❑ lump(s) in testicle(s)		
❑ prostate problem *(please specify)* ______		
② **For Women Only**		
❑ vaginal discharge → colour ______ → if you ever had vaginal infection(s), specify the year(s), # of infections & types ______		
❑ vaginal itch		
Do you still have periods? ❑ No → specify the year stopped ______ → ○ hysterectomy ○ menopause ❑ Yes → ○ irregular ○ regular → every ______ days · Usual length of periods → ______ days · Usual flow → ○ light ○ moderate ○ heavy		
❑ painful periods with cramps		
❑ PMS (premenstrual symptoms) → *(specify)* ______		
❑ ovary pain or problem → Have you ever been diagnosed with ovarian cyst(s)? ○ No ○ Yes → When? ______		
❑ painful intercourse		
Approximately when did you have your last Pap smear *(e.g. January 2003)*? ______		
❑ breast problem → ○ pain ○ lump(s) or cyst(s) → If you have ever had lump(s) or cysts(s) treated, please specify result(s) and the year(s) ______		
Have you had mammogram(s)? ❑ No ❑ Yes → please specify the year(s) and result(s) ______		

Have you had any of the following symptoms in the last 12 months? *(please check all that apply)*

8. Musculoskeletal *(if you have noticed anything triggers your symptoms or helps relieve them, please specify)*

Symptoms | Triggers | Helpers

- ☐ muscle discomfort / pain not related to over-exercise
  - ○ upper body left side ○ upper body right side
  - ○ lower body left side ○ lower body right side
  - ○ neck muscles ○ mid back ○ lower back
- ☐ muscle pain after exercise associated with activities of daily living (e.g. doing laundry, walking up stairs, etc.)
  - ➟ number of hours of pain ______ OR number of days of pain ______
- ☐ fatigue after exercise associated with activities of daily living (e.g. doing laundry, walking up stairs, etc.) ➟ number of hours of fatigue ______ OR number of days of fatigue ______
- ☐ number of minutes you can comfortably walk per day
  - ➟ on a good day ______ on a bad day ______
- ☐ generalized muscle weakness ➟ ○ constant ○ off and on
- ☐ weakness in particular muscles ➟ *please specify where* ______
- ☐ joint problems ➟ *please check all joints that have been painful, swollen or red:*

	painful	swollen	red		painful	swollen	red
left shoulder				right shoulder			
left elbow				right elbow			
left wrist				right wrist			
left hand				right hand			
left fingers				right fingers			
left hip				right hip			
left knee				right knee			
left ankle				right ankle			
left foot				right foot			
left toes				right toes			

- ☐ back joint problems ➟ ○ neck ○ upper back ○ mid back ○ lower back
- ☐ other(s) *(please specify)* ______

9. Skin *(if you have noticed anything triggers your symptoms or helps relieve them, please specify)*

- ☐ generalized itching *OR* ☐ itchy areas ➟ *please specify:* ______
- ☐ hives
- ☐ unexpected hair loss ➟ *please specify where:* ______
- ☐ excessive dry or flaky skin
- ☐ eczema
- ☐ acne ➟ antibiotic used? ○ No ○ Yes → *length of time used:* ______
- ☐ psoriasis
- ☐ athlete's foot or ringworm
- ☐ nail problems ➟ *please specify (e.g. fungal infection, etc.):* ______
- ☐ cracking heels or finger tips
- ☐ pre-cancer spots ➟ If you have ever had a skin cancer removed, please specify type(s) and the year(s) ______
- ☐ other(s) *(please specify)* ______

IMMUNIZATION HISTORY

Have you had the following immunizations?

- ☐ BCG (for TB)
- ☐ Hepatitis A
- ☐ Meningitis
- ☐ Chicken Pox
- ☐ Rubella
- ☐ Tetanus ➟ Year of last booster: ______
- ☐ Polio ➟ Year of last booster: ______
- ☐ Influenza ➟ Year of last booster: ______
- ☐ Hepatitis B ➟ Year of last booster: ______
- ☐ Other(s) ➟ *(please specify)* ______

Family History

Relative	If Living				If Deceased		
	Present Age	Present Health Problems	Past Health Problems	Main Occupation	Age at Death	Date of Death	Cause of Death
Mother							
Father							
Sister(s) *(in age order from oldest to youngest)*							
Brother(s) *(in age order from oldest to youngest)*							
Spouse *or* **Companion**							
Previous Spouse *(if applicable)*							
Daughter(s) *(in age order from oldest to youngest)*							
Son(s) *(in age order from oldest to youngest)*							

Country of birth:						
	mother		mother's father (maternal grandfather)		mother's mother (maternal grandmother)	
	father		father's father (paternal grandfather)		father's mother (paternal grandmother)	

Has any blood relative of yours ever had any of the following conditions?

- * ***Please check all that apply*** **and** ***specify relationship*** **– immediate relatives (e.g. parents, brothers, sisters, children) and extended family (e.g. grandparents, aunts, uncles, cousins, etc.) on your mother's and father's sides.**
- * **Please also specify type of condition (e.g. of cancer) or known triggers (e.g. of allergies).**

✓	Condition	Immediate Relatives	Extended Family (Mother's side)	Extended Family (Father's side)	Type or known triggers
	Addiction				
	Allergies				
	Alzheimer's disease				
	Asthma				
	Bleeding tendency				
	Cancer				
	Chronic lung disease				
	Diabetes				
	Glaucoma				
	Heart disease				
	High blood pressure				
	Migraine				
	Nervous trouble				
	Stroke				
	Suicide				
	Thyroid trouble				
	Any other disease(s) that run(s) in your family?				

Exposure History

COMMUNITY

For each of the items listed below: **Do you presently live nearby** (within 300 m- about 3 mid-sized city blocks)

If you have ever lived nearby, please write the number of years in the appropriate age group(s).

Item					Age: 0-5	6-17	18-40	41-64	65+
Heavy traffic	☐ No	☐ Yes	*(please specify)*	☐ highway ☐ busy street					
Vehicle idling area	☐ No	☐ Yes	*(please specify)*	☐auto ☐ bus / truck					
Dump site(s)	☐ No	☐ Yes	*(please specify types)*	______					
Areas sprayed with pesticides:	☐ No	☐ Yes	*(please specify type)* e.g. Farm(s), Orchard(s), Golf Course	______					
Industrial plant(s)	☐ No	☐ Yes	*(please specify types)*	______					
Polluted lake / stream	☐ No	☐ Yes	*(please specify types)*	______					
Nuclear power plant	☐ No	☐ Yes							
Electricity towers	☐ No	☐ Yes							
Airport	☐ No	☐ Yes	*(please name)*	______					
Cellphone towers	☐ No	☐ Yes	*How many?*	______					
Other potential hazards	☐ No	☐ Yes	*(please specify type)*	______					

Commute ☐ No ☐ Yes *How long both ways?* ______ min *Type of transportation:* ______

Do you protect yourself from excess sun exposure? ☐ rarely ☐ occasionally ☐ often/always ☐ using clothing ☐ sun block

Use tanning bed? ☐ No ☐ Yes (*How often?*) ______ **Use tanning solutions?** ☐ No ☐ Yes (*How often?*) ______

HOME & HOBBY

How long have you lived in your present residence? ______ **How old is it?** ______

Is your residence? ☐ On a First Nations reserve→ *(please name)* ______ ☐ house (detached) ☐ house (semi-detached) ☐ mobile home ☐ apartment → ☐ basement # of floors___ your floor ____ On what floor is your bedroom?_____ Age of your mattress_____

Do you use dust mite-proof: Pillow cover(s)? ☐ No ☐ Yes Mattress cover(s)? ☐ No ☐ Yes

Ownership? ☐ owner occupied ☐ rental ☐ co-op ☐ public housing

How is your home heated? ☐ forced air ☐ hot water radiators ☐ space heater ☐ baseboard heaters ☐ other ______

What type of fuel is used for heating? ☐ natural gas ☐ oil ☐ wood ☐ electricity ☐ propane

Has your home or apartment building been tested for radon? ☐ No ☐ Yes

Have any renovations been done since you've moved in? ☐ No ☐ Yes → When?______ What? ______

Do you use: ☐ central vacuum? ☐ HEPA filter vacuum? ☐ other vacuum? (*please specify*) ______

What is your water source for bathing? ☐ city ☐ well ☐ other (*please specify*) ______

What product(s) do you usually use in your home? *(please specify brands)*

bathroom cleanser ______ floor / wall cleanser ______ window cleaner ______

laundry detergent ______ liquid fabric softener ______ dryer sheets ______

For each of the items listed below, do you presently have/use:

If you ever had, please write down the number of years in the appropriate age group(s)

Item			Age: 0-5	6-17	18-40	41-64	65+
Basement cracks *or* dirt floor	☐ No	☐ Yes *(circle which one or both)*					
Damp, musty basement *or* crawl space	☐ No	☐ Yes *(circle which one or both)*					
Wet windows or outside closet walls (condensation)	☐ No	☐ Yes → O slight O severe					
Water leaks or water damage	☐ No	☐ Yes → O slight O severe → *Where?*					
Visible mould	☐ No	☐ Yes → O slight O severe → *Where?*					
Crumbling pipe insulation	☐ No	☐ Yes → O slight O severe					
Flaking paint	☐ No	☐ Yes → O slight O severe					
Stagnant stuffy air	☐ No	☐ Yes → O slight O severe					
Gas or propane stove	☐ No	☐ Yes *(circle which one or both)*					
Other gas appliances	☐ No	☐ Yes *(please specify)*					
Microwave	☐ No	☐ Yes					
Wood stove or fireplace	☐ No	☐ Yes *(circle which one or both)*					
Air conditioning	☐ No	☐ Yes → O central O individual rooms					
Electrostatic air cleaner	☐ No	☐ Yes					
Other air cleaner(s)	☐ No	☐ Yes *(please specify)*					
Deodorizer	☐ No	☐ Yes *(please specify)*					
Carbon Monoxide Detector	☐ No	☐ Yes → How many? ________					
Smoke detector	☐ No	☐ Yes → How many? ________					
Smoking at home	☐ No	☐ Yes → Who smoked? ________					
Smoking in car	☐ No	☐ Yes → Who smoked? ________					
WiFi / Router	☐ No	☐ Yes → When did you install? ________					
Smart meter	☐ No	☐ Yes → *Where?* ________					
Carpets	☐ No	☐ Yes → *Where?* ________ *How old?* ________					
Vinyl linoleum	☐ No	☐ Yes → *Where?* ________ *How old?* ________					
Pesticides	☐ No	☐ Yes → *Where?* ________					
Pets	☐ No	☐ Yes *(please specify kind & number)*					
Pets sleep in your bedroom	☐ No	☐ Yes					
Indoor plants	☐ No	☐ Yes → *How many?*					
Garage	☐ No	☐ Yes → ☐ attached ☐ underground					
Furniture stripping / refinishing	☐ No	☐ Yes *(please specify type)* ________					
Home renovating (hobby)	☐ No	☐ Yes *(please specify type)* ________					
Art work	☐ No	☐ Yes *(please specify type)* ________					
Other non-occupational activities with exposure to toxic chemicals (hobbies)	☐ No	☐ Yes *(please specify type)* ________					

What hobbies do members of your household have?

Do you participate in sports? ☐ No ☐ Yes *(please specify what & how often)*

____

OCCUPATION

Do you presently do volunteer work and/or work for pay?

☐ Yes ☐ No

If yes,	☐ Volunteer work → *Number of hours per week:* ______ *Type:* ______
	☐ Work for pay → *Number of hours per week:*
If no,	☐ Unable to work for pay due to health problems → *Date stopped work:*
	Reason(s): ______
	☐ On disability benefits → ☐ ODSP ☐ CPP ☐ WSIB ☐ Other *(please specify)*______ OR Disability claim ☐ *unresolved* ☐ *permanently denied*

Starting with your present or most recent job, please list all of the paying jobs you have ever had (including summer jobs). *Please use additional paper if necessary.*

* Please list the significant chemicals, dusts, fibres, fumes, radiation, biologic agents (e.g. bacteria, moulds, viruses), electromagnetic fields and physical agents (e.g. extreme heat, cold, vibration, noise) that you were exposed to at this job.

** Please list any protective measures taken (e.g. showering at work, laundering clothes at work, etc.) or protective equipment used (e.g. gloves, apron, mask, respirator, hearing protectors, etc.).

Company Name & Work Location	From Mth / Yr	To Mth / Yr	Job Title & Description	Exposures*	Protective Measures / Equipment **
1.	/	/			
2.	/	/			
3.	/	/			
4.	/	/			
5.	/	/			
6.	/	/			
7.	/	/			

Have you ever served in the military? ☐ No ☐ Yes → *when?*______ *where?*______

The following questions are about your present or most recent work environment:

Age of Building: ______ Number of Floors: ______ Approximate number of occupants: ______

Neighbourhood: ☐ rural ☐ commercial ☐ industrial Smoking allowed on property? ☐ No ☐ Yes

Which of the following are / were on the same floor as your work station in your present or most recent work?

☐ banks of computers ☐ WiFi ☐ unvented copy machines ☐ partitions or room dividers

☐ central air conditioning ☐ windows that open ☐ carpets → *How old?*______ ☐ co-workers wearing perfume

☐ number of co-workers complaining of feeling ill at work ______ *Please specify symptoms* ______

Can / could you smell odours from the following in your present or most recent work environment?

☐ laboratory ☐ cafeteria ☐ manufacturing area ☐ idling vehicles ☐ parking garage

Have any of the following occurred in your work environment over the past 12 months or the last 12 months you worked in your most recent job?

☐ use of pesticides → O indoors O outdoors ☐ fire, smoke ☐ flood, water leaks ☐ carpet cleaning

☐ new flooring, furniture, etc. *(please specify)* ______ ☐ painting ☐ deodorizer use

☐ construction or ☐ renovation or ☐ chemical spill, leak *(please specify)* ______

☐ stress *(please specify)* ______

SCHOOL

(Complete this form only if you are going to school OR if your child is the patient and is going to school)

☐ not applicable to me

Personal or Child's level of education (Please check one)

No formal schooling ☐ Some primary ☐ Completed primary ☐ Some secondary or high school ☐ Completed secondary or high school ☐ Diploma/Apprenticeship ☐ Some University ☐ Completed University degree (please specify)________________

How old is your or your child's school? ________ Number of floors: ________ Number of occupants: ________

Have additions been made to the original building? ☐ No ☐ Yes → When? ______________

Number of portable classrooms in use:__ Hours per day you or your child spends in a portable classroom:_______

School neighbourhood: ☐ rural ☐ suburban ☐ urban

Is your or your child's school located near (within 300 m or about 3 city blocks) of any of the following:

Heavy traffic	☐ No	☐ Yes *(please specify)*	☐ highway	☐ busy street
Vehicle idling area	☐ No	☐ Yes *(please specify)*	☐ auto	☐ bus / truck
Dump site	☐ No	☐ Yes *(please specify type)*	______________	
Farm(s)	☐ No	☐ Yes *(please specify type)*	______________	
Industrial plant(s)	☐ No	☐ Yes *(please specify type)*	______________	
Polluted lake / stream	☐ No	☐ Yes *(please specify type)*	______________	
Nuclear power plant	☐ No	☐ Yes		
Electric towers	☐ No	☐ Yes		
Cell Towers	☐ No	☐ Yes		
Other potential hazards	☐ No	☐ Yes *(please specify type)*	______________	

Which of the following does your or your child's school have? *(Please check all that apply)*

☐ carpeted classrooms	☐ central air conditioning	☐ art room – exhaust hood?	☐ No	☐ Yes
☐ unvented copy machine(s)	☐ windows that open	☐ laboratory – exhaust hood?	☐ No	☐ Yes
☐ flaking paints	☐ mouldy smell	☐ workshop – exhaust hood?	☐ No	☐Yes
☐ laptops	☐ WiFi hubs *When installed?* _______			

Have any of the following occurred in your or your child's school during the current or last school year?
(Please check all that apply)

☐ carpet cleaning ☐ construction ☐ renovation ☐ painting

☐ new flooring or furniture *(please specify)* ____________ ☐ flood, water leaks ☐ roof tarring

☐ use of pesticides / herbicides → ☐ indoors ☐ outdoors

Are the following products used in your or your child's school during the school year?
(Please check all that apply)

☐ deodorizers	☐ furniture wax or polish	☐ odourous cleaning products
☐ deodorant sprays	☐ floor wax	☐ scented washroom soap
☐ spray paints	☐ permanent markers	☐ strong-smelling art supplies

Does your or your child's school have a policy regarding the use of personal scented products by staff and students?

☐ No ☐ Yes *(please specify)* → ☐ prohibition of scented products ☐ encouragement of unscented products

Exposure History

PERSONAL

Natural Inhalant Allergies

Have you ever had allergy tests or treatments?
(seasonal pollens, animal danders, dust, mites, or moulds)?

☐ No ☐ Yes *If YES, please specify below:*

Approx. Age	Approx. Year	Type of Test	Positive Results (please specify)	Treatments (e.g. avoidance, shots, medications)	Improvement after 1 year 0 = worse 1 = none 2 = a little 3 = some 4 = a lot

Synthetic Chemicals

Have you ever had symptoms you linked with exposure to any synthetic (man-made) chemical at a level that did not seem to bother most people?

'*Linked*' means that the symptom started or worsened within 48 hours after you were exposed to something, and/or the symptom improved or disappeared after you were no longer exposed to it.
'*Exposure*' means being near, touching, smelling, breathing in, eating, drinking, swallowing or injecting something.

☐ No If YES, *please specify chemical(s) and symptom(s) below (please use additional paper, if necessary).*

Man-made Chemical	Symptoms Linked with Low Level Exposure	Presently Affected? 1 = a little 2 = somewhat 3 = a lot	With avoidance, how long for symptoms to disappear? 1 = mins 2 = hours 3 = days

Do you use SCENTED personal or hair products? *(please check)* ☐ No ☐ Yes *If YES, please specify below:*

Scented Products	Soap	Lotion	Cosmetics	Perfume/ Cologne/ Aftershave	Hair permanent	Hair colour	Hair Spray	Other(s) (please specify)
Infrequently	☐	☐	☐	☐	☐	☐	☐	☐ ______
Daily	☐	☐	☐	☐	☐	☐	☐	☐ ______

Smoking History

Do you currently use tobacco (daily or almost every day)?

☐ No ☐ Yes *(please specify)* → ☐cigarettes ☐cigars ☐pipe ☐snuff ☐chewing tobacco

If YES, average number per day: _____ # of years: _____ Interested in a smoking cessation program? ☐ No ☐ Yes

If NO, have you ever used tobacco (daily or almost every day)? ☐ No ☐Yes

- If YES, number of years you used tobacco: ______________ Average number per day: ______________
- Date you last used tobacco regularly: Year ______________

Have you ever experimented with "recreational drugs"? ☐ No ☐ Yes → What drugs? ______________
What age/s? ______________

Artificial Materials

How many metal dental fillings / caps do you currently have? silver / mercury __________ gold __________

Have you had silver / mercury fillings removed? ☐ No ☐ Yes → Number removed: _____ Year(s): _________

Do you have a bridge, denture or partial plate? ☐ No ☐ Yes → Number of Year(s): _________

Do you have other artificial materials in your body? (e.g. pins, screws, plates, meshes, valves, implants, etc.)

☐ No ☐ Yes *(please specify)* ____

Do you have body art? ☐ No ☐ Yes → ☐ Tattoos → Number :______ ☐ Piercings → Number:________

Electromagnetic Fields ``Screen Time``

How often do you use: *(please circle)*	Infrequently		Daily			
	never/rarely	< once/week	<30 min	1-3 hrs.	4-7 hrs.	8 hrs or more
Cell phone	☐	☐	☐	☐	☐	☐
Cordless phone	☐	☐	☐	☐	☐	☐
Laptop computer	☐	☐	☐	☐	☐	☐
Desktop computer/video display unit	☐	☐	☐	☐	☐	☐
Remote headset	☐	☐	☐	☐	☐	☐
Wireless Devices (i.e. TV, mouse, keyboard)	☐	☐	☐	☐	☐	☐

Blood Transfusion, Immunization Reaction, Travel Illness

Have you had blood transfusion(s)? ☐ No ☐ Yes →*Year(s)*__________ Circumstances? __________________

Have you had abnormal reactions to immunizations? ☐ No ☐ Yes →Type_____________ *Year(s)*___________

Have you ever experienced significant symptoms when travelling? ☐ No ☐ Yes→

Please specify year, location, symptoms: ____

Living Situation / Supports / Stresses

Who lives at home with you? ____

Are you: ☐ single ☐ married / cohabitating ☐ separated ☐ divorced ☐ widowed

Do you have inner or spiritual beliefs or mindfulness activities which help you cope?

☐ No ☐ Yes *(please specify)* ____

Are you part of a social or religious community which helps you cope?

☐ No ☐ Yes *(please specify and estimate the number of contacts in the last 12 months)*__________________

Who backs you up best with your present health problems? ______________________________

What other supports do you have? ____

Type of Stress	Ever had it?	When? *Specify year(s)*	Comments (e.g. who or circumstances involve
Loss of someone close	☐ No ☐ Yes		
Severe illness- someone close	☐ No ☐ Yes		
Poverty (family income less than $20, 000 /yr)	☐ No ☐ Yes		
Loss of job	☐ No ☐ Yes		
Change of job or workplace	☐ No ☐ Yes		
Household move	☐ No ☐ Yes		
Marriage	☐ No ☐ Yes		
Separation	☐ No ☐ Yes		
Divorce	☐ No ☐ Yes		
Pregnancy	☐ No ☐ Yes		
Alcohol / drug addiction	☐ No ☐ Yes		
Alcohol / drug addiction in someone close	☐ No ☐ Yes		
In jail	☐ No ☐ Yes		
Physical abuse	☐ No ☐ Yes		
Emotional abuse (being put down, called names)	☐ No ☐ Yes		
Sexual abuse	☐ No ☐ Yes		
Other *(please specify)*	☐ No ☐ Yes		

Exposure History

DIET

Who grocery shops?________________________ Who cooks?______________________________________

Please indicate the top 3 foods, snacks, beverages and combinations you typically consume in a week (e.g. wheat cereal, sugar and milk):

Foods / Snacks /Combinations	*Please Specify*			Beverages
Breakfast	1.	2.	3.	
Mid-Morning	1.	2.	3.	
Lunch	1.	2.	3.	
Mid-Afternoon	1.	2.	3.	
Dinner	1.	2.	3.	
Evening	1.	2.	3.	

Do you eat organic food? ☐ No ☐ Yes → *circle how often:* Rarely/About once/wk/2 times/wk/Daily/Several x daily

Do you eat foods with food colouring? ☐ No ☐ Yes → *circle how often:* Rarely/About once/wk/2 times/wk/Daily/Several x daily

Do you use artificial sweetener? ☐ No ☐ Yes → On average, how many days per week?______ How many times per day?__________

Do you eat fish or seafood? ☐ No ☐ Yes → on average, how many days per week? ____ How many times per day? ______________

Type(s) of fish or seafood eaten e.g. tuna, shark, swordfish, local fish, salmon, tilapia, shrimps, oysters, other.:_________________ Wild______ Farmed____

Do you eat hunted game meat? ☐ No ☐ Yes → Type_____ On average, how many days per week? ____ How many times per day? ____

How much of the following beverages do you consume regularly and have you linked any symptoms?

☐ **water** → Number of 8 oz glasses per 24 hours _______ ☐ city ☐ well water ☐ charcoal-filtered ☐ distilled
☐ reverse osmosis ☐ bottled (glass) ☐ bottled (plastic) Any symptoms linked?_________________________

☐ **beer, ale** → Number of 12 oz bottles per week ________ Any symptoms linked?_____________________________

☐ **wine** → Number of 6 oz glasses per week ________ Any symptoms linked?_______________________________

☐ **spirits** (e.g. whisky, rum, gin, vodka) → Number of 1½ oz drinks per week ______Any symptoms linked?________________

☐ **coffee** → Number of 8 oz cups per 24 hours ________ Any symptoms linked?______________________________

☐ **tea** → Number of 8 oz cups per 24 hours ______ Please specify type? ________ Any symptoms linked? ____________

☐ **sodas**→ Number of drinks per 24 hours ________ Please specify __________ Any symptoms linked_________________

☐ **cola** → Number of 12 oz drinks per 24 hours ______ ☐ regular ☐ diet Any symptoms linked?___________________

☐ **energy drinks** → Number of 12 oz drinks per 24 hours __Amount of caffeine/drink__ Any symptoms linked?__________

☐ **other(s)** *(please specify)* ________________________________Any symptoms linked?_____________________

Please list foods / beverages that do not agree with you (e.g. stuffy runny nose, headache, heartburn, bloating, diarrhea, sleepiness, difficulty thinking or concentrating, etc.) **or trigger allergic reactions** (e.g. hives, rashes, shortness of breath, wheezing, anaphylaxis, etc.):

List foods / beverages that are a problem	What problem(s) do they give you?	With avoidance, how long for symptoms to disappear?			Approximately how often do you eat / drink them?			
		Mins	Hrs	Days	Never	Occasionally	Daily	> once a day

Please list any foods / beverages that you crave or help you to feel better:

List foods / beverages that you crave or help you to feel better	Time(s) of craving	What problem(s), if any, do they give you?	Approximately how often do you eat / drink them?			
			Never	Occasionally	Daily	> once a day

DRUG

Please list all PRESCRIPTION medications you currently take on a regular basis, including birth control pills and allergy injections *(please use additional paper if necessary)*:

Name of prescription medication	Dose (e.g. mg, ml, IU)	How often do you take it?	How long have you taken it?	If you have side effects, please specify

Have you ever taken steroids? ☐ No ☐ Yes → ☐ Nose Spray ☐ Inhaler ☐ By Mouth

Please specify when ______

Have you ever taken antibiotics for more than one month? ☐ No ☐ Yes →

List condition(s) ______ When ______ Name of antibiotic(s) ______

Have you ever used antifungals?? ☐ No ☐ Yes → ☐ By Mouth ☐ Cream/Gel ☐ Shampoo

List condition(s) ______ When ______ Name of antifungal(s) ______

Please list all NON-PRESCRIPTION medications you currently take on a regular basis, including vitamins, minerals, herbs, remedies, etc. *(please use additional paper if necessary)*:

Name and brand of non-prescription medication	Dose (e.g. mg, ml, IU)	How often do you take it?	How long have you taken it?	If you have side effects, please specify

Drug Adverse Reactions: Please list ANY medication / anaesthetic / immunization you have had to stop taking because of side effects or allergic reactions:

Name of medication / anaesthetic / immunization	Type of side effects or allergic reaction that caused you to stop it	Treatment of side effects or reactions	Age	Year

12. **Have you EVER had an emergency injection of adrenaline (epinephrine) for a reaction to any medication, food, insect sting, or other substance?**
☐ No ☐ Yes → What year(s) ______

To what? ______

Do you have an EpiPen or Twinject? ☐ No ☐ Yes → *When was it prescribed?* ______