

## Exposure History Form

### Part 1. Exposure Survey

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please circle the appropriate answer.

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

- |  |    |     |              |        |
|--|----|-----|--------------|--------|
| 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**

**A. Occupational Profile**

**Name:** \_\_\_\_\_

**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.

- |  |   |  |   |
|--|---|--|---|
| <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 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? <i>Please circle those that apply.</i>		
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.