Exposure History Form

Part 1. Exposure Survey

Name: ___________________________  Date: ___________________________

Birth date: __________  Sex (circle one): Male  Female

Please circle the appropriate answer.

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

If yes, list them below

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

If yes, list the protective equipment used

10. Have you been advised to use protective equipment?  no  yes

11. Have you been instructed in the use of protective equipment?  no  yes

Developed by ATSDR in cooperation with NIOSH, 1992
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

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.

<table>
<thead>
<tr>
<th>Dates of Employment</th>
<th>Job Title and Description of Work</th>
<th>Exposures*</th>
<th>Protective Equipment</th>
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*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.

- Acids
- Alcohols (industrial)
- Alkalis
- Ammonia
- Arsenic
- Asbestos
- Benzene
- Beryllium
- Cadmium
- Carbon tetrachloride
- Chlorinated naphthalenes
- Chloroform
- Chloroprene
- Chromates
- Coal dust
- Dichlorobenzene
- Ethylene dibromide
- Ethylene dichloride
- Fiberglass
- Halothane
- Isocyanates
- Ketones
- Lead
- Mercury
- Methylene chloride
- Nickel
- PBBs
- PCBs
- Perchloroethylene
- Pesticides
- Phenol
- Phosgene
- Radiation
- Rock dust
- Silica powder
- Solvents
- Styrene
- Talc
- Toluene
- TDI or MDI
- Trichloroethylene
- Trinitrotoluene
- Vinyl chloride
- Welding fumes
- X-rays
- Other (specify)
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?  Please circle those that apply.
   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.