

CHILD TOXIN EXPOSURE QUESTIONNAIRE

If you have been exposed to any of these in the LAST 12 MONTHS please check:

- **(Y)** Yes
- **(N)** No
- **(?)** Unknown
- **(P)** for exposure before 12 months ago

| Do you have regular exposure to: | Y | N | ? | P | Notes |
|--------------------------------------|---|---|---|---|-------|
| Automobile exhaust | | | | | |
| Farm/Industrial/Power plant or lines | | | | | |
| Radio tower | | | | | |
| Landfill/Dump | | | | | |
| Hydro tower | | | | | |

Community

Home and/or Work Environment

| Do you live in a: (Circle one) | House | Apartment Building | Mobile Home | | |
|--|-------|--------------------|-------------|---|-------|
| Do you work in a: (Circle one) | House | Office Building | Factory | | |
| Bathing/Showering water source: (Circle one) | Well | Public Works | Bottled | | |
| Do you have regular exposure at home or work to: | Y | N | ? | P | Notes |
| Forced air heat | | | | | |
| Renovations (new carpets; add ons; etc...) | | | | | |
| Basement cracks or dirt floor | | | | | |
| Damp basement or crawl space | | | | | |
| Wet windows or outside closet walls | | | | | |
| Water leaks (ceilings, walls, floors) | | | | | |
| Visible mold | | | | | |
| Old or cracking ceiling tiles | | | | | |
| Old or cracking vinyl linoleum flooring | | | | | |
| Crumbling pipe insulation | | | | | |
| Crumbling wall or ceiling insulation | | | | | |
| Old or cracking paint | | | | | |
| Carpets or rugs | | | | | |
| Stagnant or stuffy air | | | | | |
| Gas or propane stove | | | | | |
| Coal or wood stove | | | | | |
| Other gas appliance (water heater, furnace) | | | | | |

| | | | | |
|------------------------------|--|--|--|--|
| Regular contact with smokers | | | | |
|------------------------------|--|--|--|--|

| Do you have regular exposure to: | Y | N | ? | P | Notes |
|----------------------------------|---|---|---|---|-------|
|----------------------------------|---|---|---|---|-------|

| | | | | |
|---|--|--|--|--|
| Pesticides or herbicides | | | | |
| Harsh chemicals (varnish, glue, gas, acid...) | | | | |
| Welding or soldering | | | | |
| Metals (Lead, Mercury, etc) | | | | |
| Paints | | | | |
| Photo developing / Dark room | | | | |
| Airplane travel | | | | |
| Cleaning chemicals | | | | |

Hobby and Work Activities

Personal - Diet

| | | | | |
|--|---|---|---|-------|
| | Y | N | ? | Notes |
|--|---|---|---|-------|

Dental

| | | | | | |
|--|----------|--------------|----------|----------|--------------|
| Drinking/Cooking water source: | Well | Public Works | Bottled | Filtered | |
| Caffeine? What kind: | How | | | | |
| | Much: | | | | |
| Do you regularly eat: | | | | | Notes |
| Fish (fresh, frozen, canned, etc.) | | | | | |
| Artificial sweeteners (Circle one): NutraSweet, Equal, Aspartame, Splenda | | | | | |
| Alcohol | | | | | |
| Animal products | | | | | |
| <ul style="list-style-type: none"> • How often? • What percentage of your animal product is organic? | | | | | |
| Do you wash your produce | | | | | |
| <ul style="list-style-type: none"> • What percentage of your produce is organic? | | | | | |
| Deep fat fried foods | | | | | |
| Sodas, juices, drinks containing High Fructose Corn Syrup – how many per day? | | | | | |
| Do you have: | Y | N | ? | P | |
| Allergies | | | | | |
| Sensitivity to smells (gas, perfume, paint, etc...) | | | | | |
| Artificial materials in the body (implants, pins, joints, etc...) | | | | | |
| Immunizations | | | | | |
| Have you ever: | Y | N | ? | P | |
| Used tobacco | | | | | |
| Experimented with recreational drugs | | | | | |
| Led a high stress lifestyle | | | | | |
| Experienced a stressful or traumatic event | | | | | |
| Been under anesthesia | | | | | |
| Had an illness during foreign travel | | | | | |
| Had an illness while camping or hiking | | | | | |
| Had food poisoning | | | | | |

| | | | | |
|--|--|--|--|--|
| Do you currently have amalgam fillings or caps? | | | | |
| • How many amalgam fillings do you have now? | | | | |
| Have you removed or lost dental fillings or caps? | | | | |
| Did you have fillings as a child? | | | | |
| • How many fillings did you have? | | | | |
| Did you have your Wisdom teeth removed? | | | | |
| • At what age? | | | | |
| • Any complications such as dry socket or abscesses? | | | | |
| Do you have any root canal treated teeth? | | | | |
| • How many and when were they placed? | | | | |
| Did your mother have dental fillings prior to giving birth to you? | | | | |
| • During her pregnancy with you? | | | | |
| Other: | | | | |

School

Please list all **PRESCRIPTION** or **OVER THE COUNTER** medications you

| | | | | | |
|---|----------|----------|----------|----------|--------------|
| Age of school building: | | | | | |
| Location of school building: Rural City Suburban | | | | | |
| Do you have regular exposure at school to: | Y | N | ? | P | Notes |
| Automobile exhaust | | | | | |
| Farm/Industrial/Power plant or lines | | | | | |
| Radio tower | | | | | |
| Landfill/Dump | | | | | |
| Water tower | | | | | |
| Renovations (carpeting, ceiling tiles, rooms) | | | | | |
| Outdoor activities (recess, sports, etc.) | | | | | |
| Other: | | | | | |

currently take on a regular basis, including birth control pills and allergy injections:

| Name of medication | Dose (mg, ML, IU) | How often do you take it? | How long have you taken it? | If you have side effects, please specify |
|--------------------|-------------------|---------------------------|-----------------------------|--|
| | | | | |
| | | | | |
| | | | | |

Please list all **VITAMINS/MINERALS, HERBS, or OTHER SUPPLEMENTS**
you currently take on a regular basis:

| Name of supplement | Dose (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 / anesthetics / immunizations you have had to stop taking because of side effects or allergic reactions:

| Name of medication/ immunization | Type of side effects or allergic reaction that caused you to stop it | Age | Year |
|-------------------------------------|--|-----|------|
| | | | |
| | | | |
| | | | |