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ENVIRONMENTAL MEDICINE

HEALTH HISTORY QUESTIONNAIRE

Please answer the following questions to the best of your ability. The information contained in the questionnaire will be reviewed on your first visit. If there are any areas that you aren't sure about, please leave them blank.
PLEASE DO NO WEAR PERFUMES OR SCENTED PRODUCTS TO OUR OFFICE.

Identification Data: (Please Print)

Name _____ Date _____

Address _____

Postal Code _____ Telephone (w)_____ (h)_____

Date of Birth (D) ____ (M) ____ (Y) ____ Age ____ Family Physician _____

Sex _____ Marital Status: Married ___ Separated ___ Divorced ___ Widowed ___ Single ___

Health Card/ OHIP # _____ Insurance Plan_____

(**PLEASE CHECK FOR A VERSION CODE ON YOUR OHIP CARD** - A LETTER IN THE BOTTOM RIGHT CORNER OF YOUR CARD. IF PRESENT, THIS LETTER IS PART OF YOUR OHIP NUMBER.)

Medications:
A. List any medications and/or vitamin, mineral, or nutritional supplements you are currently taking. Include dosages and how frequently you take these medications.

Do you take any of the following medications daily or as often as 2-3 times a week? If yes, please circle.

Antacids Aspirin or Acetaminophen Sinus or allergy medications Laxatives Nose drops/sprays

B. List any medications to which you are allergic or which cause unpleasant side effects. Please describe reaction.

Major Hospitalizations: Please list your most recent hospitalizations. (Do not include normal pregnancies.)

Year	Operation or Illness	Name of hospital	City and Province

Family History: Indicate with an X any of the following illnesses that you or your family members have had. Please give any additional information below.

	Father	Mother	Brothers	Sisters	Self		Father	Mother	Brothers	Sisters	Self
Alcoholism						Lung disease (asthma, etc.)					
Allergies						Mononucleosis (mono)					
Arthritis						Poliomyelitis (polio)					
Blood diseases (anemia, etc.)						Psychiatric condition					
Cancers or tumors						Skin disorders (eczema,					
Diabetes						psoriasis, etc.)					
Gastro-intestinal disorders (ulcers,						Thyroid disease					
colitis, Crohn's disease, etc.)						Tuberculosis					
Heart disease						Vaginal infection (chronic)					
Herpes						Venereal disease					
High blood pressure						Other					
Kidney or urinary disease											
Liver disease (hepatitis, etc.)											

Lifestyle:

Do you or have you ever smoked regularly? Yes _____ No _____ Amount per day If quit, give date

Cigarettes _____ _____

Cigars or Pipe _____ _____

Do you drink alcohol? Yes ____ No ____ How much? _____ How often? _____

Do you drink coffee or black tea? Yes _____ No _____ How many cups per day? _____

Do you exercise regularly? Yes ____ No ____ Type: _____ Frequency: _____

How many hours of sleep do you usually get? _____ How many hours of sleep do you need to feel your best? ____

Do you practice regularly any form of meditation or relaxation method? Yes _____ No _____

Type: _____ Frequency: _____

Life Change Index: Please indicate if you have experienced any of the following events **in the past two years.**

Divorce / Marital Separation	_____	Death of spouse / close family member	_____
Marriage / Marital reconciliation	_____	Fired at work / Retirement	_____
Pregnancy	_____	Change in financial state	_____
Change to a different line of work	_____	Change in eating habits	_____

Chief Symptoms: List your **main** symptoms concisely. If there is a pattern to the symptoms, please explain. Score them 1-5: 1 = least bothersome, 5 = most bothersome.

Have you had excessive weight gain? Yes _____ No _____ No. of lbs. _____ Period of weight gain _____

Have you had excessive weight loss? Yes _____ No _____ No. of lbs. _____ Period of weight loss _____

Systems Review: Please indicate how often, if ever, you experience each of the following symptoms.

	Daily	2-3 times /week	1-3 times /month	Rarely or never
GENERAL				
Constant fatigue				
Circles under eyes				
Flu-like symptoms				
EAR, NOSE, THROAT				
Itchy ears/nose/throat				
Ringing in ears				
Blocked ears				
Visual change				
Itchy eyes				
Post nasal drip				
Sinus/nasal congestion				
Runny nose				
Sneezing				
Frequent nosebleeds				
GENITOURINARY				
Urinary frequency				
Urinating at night (>1)				
MEN:				
Slow, weak urine stream				
WOMEN:				
Vaginal burning/itching				
Vaginal discharge				
Painful periods				
Heavy flow with period				
Increase in symptoms before period (PMS)				

Print the following information in the spaces at the left:

____Number of pregnancies
____Number of miscarriages
____Number of children
____Toxemia (Eclampsia) during pregnancy
Last menstrual period:_____

	Daily	2-3 times /week	1-3 times /month	Rarely or never
SKIN				
General itching				
Dry skin				
Fragile nails				
Eczema				
Psoriasis				
Rash				
Hives				
Anal itch				
Acne				
RESPIRATORY				
Dry cough				
Productive cough				
Asthma or wheezing				
Shortness of breath				
CARDIOVASCULAR				
Irregular heart beat				
Chest pain				
Swelling in ankles				
Cold extremeties				
Bruise easily				
ENDOCRINE				
Excessive thirst				
Sugar cravings				
Feeling too hot				
Feeling too cold				
Excessive hair loss				
Weight fluctuation				
GASTROINTESTINAL				
Heartburn				
Nausea				
Vomiting				
Flatulence (gas)				
Abdominal bloating				
Constipation				
Diarrhea (loose stool)				
Bloody/black stool				
MUSCULOSKELETAL				
Neck pain/tension				
Back pain				
Muscle pain				
Painful or stiff joints				
Swelling in joints				
CENTRAL NERVOUS				
Mood swings				
Irritability				
Anxiety				
Depression				
Decreased sex drive				
Headache				
Poor memory				
Hyperactive				
Difficulty sleeping				

Indicate the number of doctors you have seen for the above symptoms:

Family Physician			
Internal Medicine	Respirologist	Cardiologist	Urologist
Gastroenterologist	Endocrinologist	Rheumatologist	Dermatologist
Allergist	Clinical Ecologist	Gynecologist	Ear, Nose, & Throat
Psychiatrist	Psychologist	Neurologist	Chiropractor

Previous Evaluations (Please give year):

Chest X-ray	Kidney X-ray (IVP)	Upper G.I. Series	Gallbladder X-ray
Barium enema	EKG (ECG)	EEG	CAT scan

Do any of the following affect your symptoms?	Yes	No	?
Worse upon waking in a.m.			
Increase within 30 minutes after going to bed			
Worse indoors			
Improved outdoors			
Symptoms return with return of cold weather			
Symptoms increase in cooling evening air			
Symptoms are worse in damp places			
Symptoms are worse in basements			
Nasal symptoms while mowing grass or playing on lawn			
Worse raking leaves or playing in leaves			
Worse September to heavy (killing) frost			
Symptoms worse at ovulation			
Symptoms worse premenstrually			
Symptoms worse on clear days			
Worse outdoors 7-11:00 a.m.			
Improved in air conditioning			
Little or no symptoms when it is raining			
React to animals			
Which animals?			

Do you usually have symptoms during these months?

	Yes	No	?		Yes	No	?		Yes	No	?
January				May				September			
February				June				October			
March				July				November			
April				August				December			

Do you have 2 consecutive months that are good? List: _____

Do you have 2 consecutive months that are worse? List: _____

Do any of these items affect your symptoms? (check if affirmative)

Gasoline products	____	Varnish, paint, shellac	____	Hair sprays	____
Automobile exhaust	____	Ammonia	____	Perfumes	____
Soaps, detergents	____	Fabric softeners	____	Chlorinated water	____
Overhead power lines	____	Electric appliances	____	Electronic equipment	____
Thunder storms	____	Changes in weather	____	Fluorescent lights	____

Other _____

_____

Allergy Testing: List type of allergy tests previously done. Indicate method (ie. skin, blood, sublingual) and type (ie. inhalants, foods, chemicals).

Doctor	Date	Method	Results

Have you had allergy shots before? Yes____ No____ Date_____

Did they help? Yes____ No____ Did you react adversely? Yes____ No____

Did you have problems increasing the dose to maximum? Yes____ No____

Mark with an X if you have had:

Frequent infections: colds/sore throats____ ear infections____ vaginal infections____ bladder infections____
prostate infections____ 'Fungus infections' e.g. jock itch____ athletes foot____ infection of nails____
Other_____

Do you have a history of alcohol abuse? Yes____No____
Does alcohol affect any of your symptoms? Yes____ No____
How? _____
Have you had any side effects from vitamins? Yes____No____ Describe: _____
Have you ever taken antibiotics? Yes____ No____ How often? _____
Longer than 2 weeks in a row? Yes____No____
For acne? Yes____No____
Have you ever taken intravenous or oral cortisone, predisone, or other steroid medication? Yes____ No____
Have you had a general anaesthetic? Yes____No____ How many times?_____
Have you ever taken birth control pills? Yes____ How many years? _____ No____
Did you have any side effects? Yes____ No____ Describe_____

Work Environment:

Present occupation: _____ How long?_____
Are your symptoms worse at work? Yes____ No____
List previous occupations and dates:_____
_____
_____

Please indicate if any of the following apply to your **work environment**.

New building (under 5 yrs. old)	____	Can't open windows	____	Open or shared work space	____
Indoor garage	____	Wall to wall carpet	____	Shift work	____
Photocopying	____	Work at computer terminal	____	Work in shopping centre	____
Outside work	____	Work with smokers	____	Travel frequently	____
Work with chemicals	____	Please list_____			

Home Environment:

How long have you lived there?_____ Are your symptoms worse at home? Yes____ No____
Please indicate if any of the following apply to your home environment.

Private home	____	Heating system:		Insulation:	
# yrs. old	____	gas	____	fiberglass	____
Apartment building	____	electric	____	styrofoam	____
Mobile home	____	oil	____	UFFI (ureafoam)	____
In a wooded area	____	radiator	____	other_____	
On a farm	____	forced air	____	Drinking water:	
Garage - atttached	____	wood	____	city water	____
detached	____	Stove:		well water	____
breezeway	____	electric	____	bottled water	____
Basement - dry	____	gas	____	other_____	
damp	____	wood	____	Do you use:	
musty	____	Air conditioning:		insecticide	____
Near industry	____	whole house	____	mothballs	____
Carpeting - over 5 yrs.	____	room units	____	Home hobbies using chemicals:	
under 5 yrs.	____	Air filter:		wood refinishing	____
Renovations (within 3 yrs.)	____	fiberglass	____	photography	____
painting	____	electronic	____	painting	____
Smoking - patient	____	other_____		other_____	
spouse	____	Humidifier:		List current pets_____	
parent (in home)	____	on furnace	____	_____	
Do you wear:		room unit	____	Pets treated for fleas	____
perfume or after shave	____	Dryer vents to outside	____	did this cause symptoms?	____
make-up	____	Pillow type _____		Home sprayed for insects?	____
Mattress - regular	____	Blanket type _____		When? _____	
foam rubber	____				
waterbed	____				

Diet:

Are you on any special diet at the present time? _____

Please indicate if any of the folowing apply to you.

	Yes	No	?
Symptoms increase in late afternoon			
Do you waken from sleep between 1:00 and 5:00 a.m. with symptoms?			
What foods are you hungry for at that time? List. _____			
Do you notice itching:			
of the roof of the mouth?			
between the shoulder blades?			
inside the ear canal?			
or rash on front side of elbows			
or rash behind knees			

	Yes	No	?
Symptoms increase after meals?			
Are you excessively sleepy after meals?			
Do you eat in binges?			
Do you get canker sores in the mouth?			
Do you have a bad breath odor?			
Do you get hives?			
Do you notice that one side of your nose is blocked and the other clear and that later it is the reverse			
Do you retaste any foods after eating?			
Which foods? _____			

Please list any foods you avoid. Explain why you avoid them:

_____

_____

_____

Please list any foods you eat excessively.

_____

_____

Which foods would you miss most if taken out of your diet?

_____

_____

Diet History: Please read the following list of foods carefully and indicate how often you eat each one:

	Daily	4-5 times /week	2-3 times /week	1-3 times /month
Cow's milk (cheese, ice cream, yogurt, etc.)				
Egg (note: often in baking or breaded foods)				
Wheat (eg. bread, bran, cereal, flour)				
Corn (eg. corn starch, margarine, corn oil)				
Oats (eg. granola, cereal)				
Rye				
Rice				
Soybean (eg. soysauce, tofu, soya noodles)				
Yeast (eg. bread, cheese, mushrooms, vinegar)				
Alcohol, beer, wine, etc.				
Apples (including juice)				
Oranges (including juice)				
Grapes (including juice)				
Bananas				
Sugar				
Honey				
Soft drinks				

	Daily	4-5 times /week	2-3 times /week	1-3 times /month
Beef (eg. steak, veal, hamburger)				
Pork (eg. ham, bacon)				
Chicken				
Tuna				
Salmon				
Other fish				
Peanuts (eg. peanut butter, peanut oil)				
Nuts				
Beans				
Onion				
Garlic				
Lettuce				
Tomatoes				
Broccoli				
Cauliflower				
Potatoes				
Restaurant food				
Fast foods (eg. pizza)				
Junk foods (eg. candy)				
Chocolate				
Artificial sweetners				

Additional comments: _____

_____

_____

Thank-you.