BioFXN
Personalized Innovative Healthcare

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Powered by Rebound SportsMed

Environmental Illness and Detoxification
Initial Patient Intake Questionnaire

This form will become part of your medical record and the contents are confidential. It is very important to answer all questions as this will be most helpful in evaluating your condition.

Date_____
Name_____Birthdate_____Birthplace_____
Occupation_____Hobbies_____
List all locations in which you have lived: _____
_____

Exposure History

Community

For each of the items listed below:	Did/Do you live nearby?	Where/When/How long?
Heavy traffic(excessive)	☐ no ☐ yes (please specify)	_____
Vehicle idling area	☐ no ☐ yes (please specify)	_____
Dump site	☐ no ☐ yes (please specify)	_____
Farm(s)	☐ no ☐ yes (please specify)	_____
Industrial plants	☐ no ☐ yes (please specify)	_____
Radiation source	☐ no ☐ yes (please specify)	_____
Polluted lake/stream	☐ no ☐ yes (please specify)	_____
Other potential hazards	☐ no ☐ yes (please specify)	_____

Home & Hobby

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

If more than 40 yrs old, do you have ☐ Asbestos insulation or vinyl tile ☐ Flaking paint

What type of dwelling is your residence? ☐ House ☐ Mobile home

☐ Apartment ⇒ O basement O above store O highrise⇒floor___

Does your residence have an attached or underground garage: ☐ no ☐ yes

What type of fuel is used for heating your home: ☐ Gas ☐ Oil ☐ Wood ☐ Electric ☐ Propane

Do you have carbon monoxide detectors? ☐ no ☐ yes

Have you done any painting / renovating / bought new large furniture? ☐ no ☐ yes

⇒ If so, When? _____ What? _____

_____

Who smokes in your home? _____ Car? _____

Do or did you use pesticides or herbicides (bug or weed killers, flea / tick sprays, collars, powders, etc.) in you home or on your pets? ☐ no ☐ yes (specify) _____

_____

⇒ On your lawn or garden? ☐ no ☐ yes (specify) _____

_____

What is your water source for bathing? ☐ City ☐ Well ☐ Other_____

Occupation

1. Please list the significant chemicals, solvents, heavy metals, paints, dusts, fibers, fumes, radiation, biologic agents (bacteria, molds, viruses) and phusical agents (extreme heat, cold, vibration, noise) that you have been exposed to;
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.)

Past/Present Jobs and Hobbies	For how long did you do this?	Exposures	Protective measures and equipment
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

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

Age of building: _____ Number of floors: ___ Approximate # of occupants: ____

Neighborhood: ☐ Rural ☐ Commercial ☐ Industrial

Which of the following does / did your present or most recent work environment have?

☐ laboratory	☐ windows that open	☐ manufacturing area
☐ cafeteria	☐ banks of computers	☐ central air conditioning

☐ unvented smoking areas
☐ partitions or room dividers

☐ unvented copy machines
☐ nearby parking garage
☐ carpets – *How old?* _____

3. 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 ⇒ ☐ indoors ☐ outdoors ☐ fire, smoke ☐ flood, water leaks ☐ carpet cleaning
☐ new flooring, furniture, etc. *(specify):* _____ ☐ construction ☐ renovation
☐ painting ☐ chemical spill, leak *(specify):* _____ ☐ accidents ☐ stress

Home

1. For each of the items listed below:

	Do you have in your home?	If you ever had, please write the years:
Damp, musty basement or crawl space	☐ no ☐ yes	_____
Wet windows or outside closet walls (condensation)	☐ no ☐ yes	_____
Water leaks	☐ no ☐ yes	_____
Visible mold	☐ no ☐ yes ⇒ where? _____	
Stagnant stuffy air	☐ no ☐ yes	_____
Gas or propane stove	☐ no ☐ yes	_____
Other gas appliances	☐ no ☐ yes (*specify*) _____	
Wood stove or fireplace	☐ no ☐ yes	_____
Air Conditioning	☐ no ☐ yes	_____
	Central? Individual Rooms? _____	
Electrostatic air cleaner/filter	☐ no ☐ yes	_____
Other air cleaner(s)/filter(s)	☐ no ☐ yes	(specify)_____
Carpets	☐ no ☐ yes ⇒ *Where?* _____	
	How Old? _____	
Photocopier / fax machine / printer	☐ no ☐ yes ⇒ type? _____	
	Location? _____	
Pets	☐ no ☐ yes *(specify)* _____	
Do you use flea collars?	☐ no ☐ yes	
Indoor plants	☐ no ☐ yes *(how many?)* _____	
Do you use an electric blanket?	☐ no ☐ yes	

2. Do you dust (mite-proof)? Pillow covers ☐ no ☐ yes mattress covers ☐ no ☐ yes
Do you use? ☐ Central vacuum ☐ HEPA filter vacuum? ☐ Dust meter on vacuum?

3. What product(s) do you usually use:
Bathroom cleanser_____ floor / wall cleanser_____ window / mirror cleanser_____
Deodorizer_____ laundry detergent_____ fabric softener_____

4. What hobbies do members of your household have?_____

5. Have you personally done any of the following:

☐ furniture stripping / refinishing Years:_____

☐ home renovating Years:_____ (specify)_____

☐ art work *(e.g. painting, ceramics stained glass, leather work, etc.)* Years:_____ (specify)_____

☐ other non-occupational activities with exposure to chemicals Years:_____

Specify:_____

6. Do you: Use mothballs? ☐ no ☐ yes Burn candles? ☐ no ☐ yes

Use potpourri or air fresheners ☐ no ☐ yes Use fabric softener: ☐ no ☐ yes

Have regular manicures? ☐ no ☐ yes Use nail polish ☐ no ☐ yes

Do you: have acrylic fingernails? ☐ no ☐ yes Have your clothes dry cleaned? ☐ no ☐ yes

Remove your shoes when entering your home? ☐ no ☐ yes

Personal

1) Synthetic Chemicals

How often do you use scented personal products (please check box)

Scented Product:	Soap	Lotion	Cosmetics	Hair permanent / Hair tint		Perfume/ Aftershave	Others?
Never ☐_____	☐	☐	☐	☐	☐	☐	
Occasionally ☐_____	☐	☐	☐	☐	☐	☐	
Daily ☐_____	☐	☐	☐	☐	☐	☐	

Have you ever had symptoms you linked with exposure to any synthetic (person-made) chemical at a level that did not seem to bother most people (e.g. paints, perfumes, cosmetics, engine exhaust, tar, new cars interiors, etc.?) ☐ no ☐ yes

If YES, please specify chemical(s) and symptoms (s):

("Linked" means that the symptom started or worsened within 48 hours after you were exposed to something, or the symptom improved or disappeared after you were no longer exposed to it.

"Exposure" means being near, touching, smelling, breathing, eating, drinking, swallowing or injecting something.)

Person-Made Chemical	Symptoms Linked with Low-level Exposure	Presently Affected? 1 = a little 2 = somewhat 3 = a lot	In the Past 1 = a little 2 = somewhat 3 = a lot

2) Dental Amalgams / Implants

How many silver / mercury fillings do you currently have? _____

Have you had silver / mercury fillings removed? ☐ no ☐ yes ⇒ Number removed ___ When? ___

How many gold fillings / caps do you currently have ? _____

Do you have implants of silicone, teflon, etc. ☐ no ☐ yes If so, for how long? _____

3) Smoking history

Are you currently a smoker (daily or almost every day)? ☐ no ☐ yes
If YES, average number of cigarettes per day: _____ Number of years: _____
If NO, have you ever smoked tobacco (daily or almost daily)? ☐ no ☐ yes

- If YES, number of years you smoked: ____ Average number of cigarettes per day: ____
- When did you last smoked regularly? _____

Have you ever regularly used other tobacco products? ☐ no ☐ yes

- If YES, what / how much / and when? _____

Diet and Drug History

1. Who grocery shops for you? _____
   Where? ☐ chain grocery store ☐ health food store ☐ market ☐ other _____
2. Who cooks for you? _____
3. Please indicate foods and beverages most typically consumed for each of the following meals and the times at which they are most typically eaten.

Foods / Snacks	Please specify typical meals or foods	Time	Beverages	Please Specify	Time
Breakfast			Breakfast		
Mid-morning			Mid-morning		
Lunch			Lunch		
Mid-afternoon			Mid-afternoon		
Dinner			Dinner		
Evening			Evening		

4. How much of the following beverages do you consume regularly and have you linked any symptoms with drinking them?
   - Water ⇒ Number of 8 oz glasses per 24 hours ____ ☐ tap water ☐ filtered ☐ distilled ☐ bottled (glass) ☐ bottled (plastic) Any symptoms: _____
   - Beer, ale ⇒ Number of 12 oz containers per week ____ Any symptoms: _____
   - Wine ⇒ Number of 6 oz glasses per week ____ Any symptoms: _____
   - Spirits (e.g. whisky, rum) ⇒ Number of 1 ½ oz drinks per week ____ Any symptoms: _____
     _____
   - Coffee ⇒ Number of 8 oz cups or espresso shots per 24 hours ____ Any symptoms: _____
     _____
   - Tea ⇒ Number of 8 oz cups per 24 hours ____ Any symptoms: _____
   - Cola ⇒ Number of 12 oz drinks per 24 h ours Regular ____ Diet Any symptoms:
     _____
   - Other(s) (please specify) _____ Any symptoms: _____
5. Do you eat fish? ☐ no ☐ yes ⇒ On average how many servings (3-4 oz) per week? _____
   What are the types of fish that you eat, in order of frequency: _____

6. Please list foods / beverages that do not agree with you (e.g. stuffy nose, heartburn, bloating, diarrhea, sleepiness, difficulty concentrating, etc.) or cause 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?	Approximately how often do you eat / drink these problem foods?			
		Never	Occasionally	Daily	More than daily

7. (Disagreeable foods and reactions continued)

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

List foods that you crave or that help you to feel better	What problem(s), if any, do they give you?	Approximately how often do you eat / drink them?			
		Never	Occasionally	Daily	More than once daily