Environmental Health Factors

Automobile exhaust

Farm/Industrial/Power plant or lines

Radio tower

Landfill/Dump

Hydro Tower

Do you live in a house, apartment, mobile home

DO you work in House, office building factory

Bathing and Showering water source Well, Public, bottled

Regular exposure at home or work:

Forced air/heat

Renovations (new carpets, adds, 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

Old or cracking paint

Carpets and rugs

Stagnant or stuffy air

Gas or propane stove

Coal or woods stove

Other gas appliance (water heater,furnace)

Regular contact with smokers

Do you have regular exposer to:

Pesticides or herbicides

Harsh chemicals (varnish, glue, gas, acid, etc.)

Welding or soldering

Metals (lead, mercury, etc.)

Paints

Photo developing /Dark room

Airplane travel

Cleaning chemicals

Drinking/Cooking water source, well, public, bottled, filtered

Caffeine? What kind? How much

Do you regularly eat:

Fish (frozen, fresh, canned, etc.)

Artificial sweeteners (circle them) Nutrasweet, equal, aspartame, splenda

Alcohol

Animal products: How often? What % is organic?

Do you wash your produce? What % is organic?

Deep fat fried foods?

Sodas, juices, drinks containing high fructose corn syrup? How many ounces per day? Or cans?

Do you have:

Allergies

Sensitivity to smells (gas, perfume, paint, etc.)

Artificial materials in the body (implants, pins, joints, etc.)

Immunizations

Have you ever:

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 Or immiedately after

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 wisom teeth removed?

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 you mother have dental fillings prior to giving birth to you?

During her pregnanacy with you?

Other dental processdures?

List all prescription medications or over the counter medications you currently take on a regular basis? Including birth control and allergy medications and pain relievers/ NSAIDS

List all vitamins/minerals, herbs and other supplements you currently take on a regular basis.

Adverse side effects to ANY past or current medications, anesthetics, immunizations, foods, or supplements. (Literally anything you can put or have put in your body)