Indoor Environmental Quality-
MEDICAL SCREENING QUESTIONNAIRE

This is a strictly confidential screening questionnaire to identify possible health complaints or problems that may be associated with your work or home environmental exposures. All the responses will be reviewed by a physician specializing in occupational and environmental medicine. No personal information will be released to anyone without your written consent. Please feel free to leave out only the questions that do not directly apply to you - if necessary use the back of page for writing. If you have any questions, please contact Dr. Eckardt Johanning's office, Albany, New York (518) 459-3336.

A. IDENTIFICATION

Date: _____

Idn001 Name (Last/First) _____

Address (apt./unit) _____

City _____

Idn002 State/Zip _____

SS# _____

Phone _____ Cell: _____

Idn003 Birth date _____

Idn004 Gender Female/Male

B. MEDICAL HISTORY

Please circle

Med001 Have you ever been in the hospital as a patient ? *Yes / No*

If YES, what kind of problem were you having?

_____

Med002 Have you ever had any kind of operation? *Yes / No*

If YES, what kind?

_____

Med003 Do you take any kind of medicine regularly *Yes / No*

If YES, what kind?

_____

Med004 Are you allergic to any drugs, foods, or chemicals? *Yes / No*

If YES, what kind of allergy do you have?

_____

What triggers your allergy?

_____

Med005 Do or did you have problems of <u>atopic skin disease</u> (eczema) now or as a child *Yes / No*

Med006 Did you have any allergy skin testing in the past? *Yes / No*

Med007	Have you ever been told that you have asthma, hayfever, or sinusitis	*Yes / No*
Med008	Have you ever been told that you have emphysema, bronchitis, or any other respiratory problems?	*Yes / No*
Med009	Have you ever been told you had hepatitis?	*Yes / No*
Med010	Have you ever been told you had cirrhosis?	*Yes / No*
Med011	Have you ever been told that you had cancer?	*Yes / No*
Med012	Have you ever had arthritis or joint pain?	*Yes / No*
Med013	Have you been told that you had high blood pressure?	*Yes / No*
Med014	Have you ever had a heart attack or heart trouble?	*Yes / No*

B-1. MEDICAL HISTORY UPDATE

Med015	Have you been in the hospital as a patient any time within the past year? If YES, for what condition?	*Yes / No*
Med016	Have you been under the care of a physician during the past year? If YES, for what condition?	*Yes / No*
Med017	Is there any change in your breathing since the last last year?	*Yes / No*
Med018	If change, do you know why?	*Better / Worse*
Med019	Is your general health different this year from last year? If YES, in what way?	*Yes / No*
Med020	Do you have any eye problems, such as itchiness, dryness, inflammation? If YES, please explain	*Yes / No*
Med021	Do you have any skin problems, such as dryness, itchiness, hives or reddish spots within the last year? If YES, please explain	*Yes / No*
Med022	Have you, in the past year or are you now, taking any medication on a regular basis? If YES, name of medication	*Yes / No*

For what condition?

C. OCCUPATIONAL HISTORY

Occ001 How long have you worked for your present employer? (years) _____
What jobs have you held with this employer? (Include job title and length of time in each job)

In each of these jobs, how many hours a day were you exposed to chemical products?

Occ002 What chemical product have you worked with most of the time? (Please circle or list)

Spray paint Solvents Glues Paint Thinner

List others:

Occ003 Have you ever noticed any type of skin rash you feel was related to your work? *Yes / No*

Occ004 Have you ever noticed that some kind of chemical makes you cough? *Yes / No*

Occ005 Have you ever noticed that some kind of chemical makes you wheeze? *Yes / No*

Occ006 Have you ever noticed that some kind of chemical makes you become short of breath or cause your chest to become tight? *Yes / No*

Occ007 Are you exposed to any particular dust or chemicals at home? *Yes / No*
If YES, please explain:

Occ008 In other jobs, have you had exposure to (circle):

Wood dust	Chrome	Asbestos
Organic solvents	Urethane foams	

C-1. OCCUPATIONAL HISTORY UPDATE

Occ009 Are you working on the same job this year as you were last year? *Yes / No*
If NO, how has your job changed?

Occ010 How many hours do you work per week? (hours)
Where is your regular workplace located? (indicate bldg/floor/ office/room)

What chemicals are you exposed to on your job?

Occ011 How many hours a day are you exposed to chemicals?
Occ012 Have there been any water leaks in your workplace? *Yes / No*
If YES, describe:

Occ013 Have you noticed any visible stains on the walls? *Yes / No*
Occ014 Visible stains on the ceiling or ceiling tiles? *Yes / No*
Occ015 Does your work area have a musty odor *Yes / No*
Occ016 Have you noticed mold or mildew? *Yes / No*
If YES, explain:

Occ017 Have you noticed any skin rash you feel was related to your work? *Yes / No*
If YES, explain:

Occ018 Have you noticed that any chemical makes you cough, be short of breath, or wheeze? *Yes / No*
If YES, can you identify it

C-2. HOME ENVIRONMENT

Hen001 Please provide us with some information about your current home (circle):

Apartment House Duplex Coop

Hen002 Age of building (years) _____

Hen003 Type of heating (circle):

Forced hot air	Water/ steam	Electric	Gas	Oil

Hen004 How many people are there in your household? _____

Hen005 Are there smokers in your apartment/household? *Yes / No*

Hen006 Are there pets in your apartment/household *Yes / No*

If YES, please specify

Hen007 Do you use pesticides (ant/roach control) chemicals at home? *Yes / No*

Hen008 Do you use a humidifier at home? *Yes / No*

Hen009 Do you have wall to wall carpeting in your home? *Yes / No*

Hen010 Have there been any water leaks in your home or apartment? *Yes / No*

Hen011 Have you notice visible stains on the walls? *Yes / No*

Hen012 Visible stains on ceiling tiles? *Yes / No*

Hen013 Does your home/apartment have a musty odor? *Yes / No*

Hen014 Have you noticed mold or mildew? *Yes / No*

Hen015 Have you had any air quality or environmental survey done in your home/apartment? *Yes / No*

If YES, what were the results?

D. MISCELLANEOUS

Mis001 Do you smoke? *Yes / No*

Mis002 If YES (circle):

Cigars	Cigarettes	Pipe

Mis003 How much and for how long? _____ *years*

Mis004 Do you drink alcohol in any form? *Yes / No*

Mis005 If YES, how much and how often (circle)?

Daily	5 x week	2 x week	1 x week	Less than 1 x week

Mis006 Do you wear glasses or contact lens? *Yes / No*

Mis007 Do you get any physical exercise (other than on your job)? *Yes / No*

If YES, explain:

Mis008 Do you have any hobbies or "side jobs" that require you to use chemicals, such as furniture stripping, sand blasting, insulation or manufacture of urethane foam, furniture, etc.? *Yes / No*
If YES, please describe, giving type of business or hobby, chemical used, and length of exposure

Mis009 Are you physically affected by auto exhaust, perfumes, washing detergents, diesel fumes? *Yes / No*

E. Current symptoms questionnaire

Csq001 Do you have any shortness of breath? *Yes / No*

Csq002 If YES, do you have to rest after climbing several lights of stairs? *Yes / No*

Csq003 If YES, if you walk on the level with people your own age, do you walk slower than they do? *Yes / No*

Csq004 If YES, if you walk slower than a normal pace, do you have to limit the distance that you walk? *Yes / No*

Csq005 If YES, do you have to stop and rest while bathing or dressing? *Yes / No*

Csq006 Do you cough as much as three months out of the year? *Yes / No*

Csq007 If YES, have you had this cough for more then two years? *Yes / No*

Csq008 If YES, do you ever cough anything up from chest? *Yes / No*

Csq009 Do you have a feeling of smothering, unable to take a deep breath, or tightness in your chest? *Yes / No*

Csq010 If YES, do you notice this on any particular day of the week? *Yes / No*

Csq011 If YES, what day of the week (circle)

Mon	Tue	Wed	Thur	Fri	Sat	Sun

Csq012 If YES, do you notice that this occurs at any particular place? *Yes / No*

Csq013 If YES, do you notice that this is worse after you have returned to work after being off for several days? *Yes / No*

Csq014 Have you notice any wheezing in your chest? *Yes / No*

Csq015 If YES, is this only with colds or other infections? *Yes / No*

Csq016 Is this caused by exposure to any kind of dust or other material? *Yes / No*

If YES, what kind?

Csq017 Have you notice any burning, tearing, or redness of your eyes when you are at home? *Yes / No*

If YES, explain circumstances

Csq018 Have you noticed any sore or burning throat or itch or burning nose when you are at your home? *Yes / No*

If YES, explain circumstances

Csq019 Have you noticed any stuffiness or dryness of your nose? *Yes / No*

Csq020 Do you ever have swelling of the eyelids or face? *Yes / No*

Csq021 Have you ever been jaundiced? *Yes / No*

Csq022 Have you ever had a tendency to bruise easily or bleed excessively? *Yes / No*

Csq023 Do you have frequent headaches that are not relieved by aspirin or TYLENOL? *Yes / No*

Csq024 If YES, do they occur at any particular time of the day or week? *Yes / No*

Csq025 If YES, when do they occur (circle)?

Mon	Tue	Wed	Thur	Fri	Sat	Sun

Csq026 Do you have frequent episodes of nervousness or irritability? *Yes / No*

Csq027 Do you tend to have trouble concentrating or remembering? *Yes / No*

Csq028 Do you feel dizzy, light-headed, excessively drowsy or like you have been drugged? *Yes / No*

Csq029 Does your vision ever become blurred? *Yes / No*

Csq030 Do you have numbness or tingling of the hands or feet or other parts of your body? *Yes / No*

Csq031 Have you have excessive malaise or chronic fatigue? *Yes / No*

Csq032 Have you ever had any swelling of your feet or ankles to the point where you could not wear your shoes? *Yes / No*

Csq033 Are you bothered by heartburn or indigestion? *Yes / No*

Csq034 Do you ever have itching, dryness, or peeling and scaling of the hands? *Yes / No*

Csq035 Do you ever have a burning sensation in the hands, or reddening of the skin? *Yes / No*

Csq036 Do you ever have cracking or bleeding of the skin on your hands? *Yes / No*

Csq037 Are you under a physician's care? *Yes / No*

If YES, for what are you being treated?

Csq038 Do you have any physical complaints today? *Yes / No*

If YES, explain:

Csq039 Do you have other health complaints or conditions not covered by these question? *Yes / No*

If YES, explain:

WORK / ENVIRONMENT

During the last six months have you been bothered by any or several of the following factors in your work environment or home (if this is the problem area)?

		Always	*Sometimes*	*No/never*
Wef001	Draft			
Wef002	Room temperature too high			
Wef003	Room temperature too variable			
Wef004	Room temperature too low			
Wef005	Stuffy “bad” air			
Wef006	Unpleasant smell			
Wef007	Static electricity often causing shocks			
Wef008	Passive smoking			
Wef009	Noise			
Wef010	Poor lighting			
Wef011	Glare/reflection			
Wef012	Dust and dirt			

WORK CONDITIONS

		Often	*Some-times*	*Seldom*	*No*
Wco001	Do you regard your work as interesting and stimulating?				
Wco002	Do you feel overburdened by your job?				
Wco003	Do you have any power to define or change your work environmental condition?				

Any additional information you feel we should know? Do you have any pictures and environmental survey reports that describe the conditions in your home?

Thank you very much for your cooperation!

<u>Please return the completed questionnaire to:</u>

Dr. med. E. Johanning, M.D., MSc, Fungal Research Group,
4 Executive Drive, Albany, NY 12203