Environmental Medicine Questionnaire

A EUROPAEM Initiative
In cooperation with the Medical Quality Group of the
Environmental Medicine Continuing Education Course
July 2012 – February 2013

Patient	
Born on:	

	GENERAL INFORMATION		
	Nationality		
	Height and weight		
	How tall are you? (cm)		
	How much do you currently weigh? (kg)		
	Changes in body weight over the **last 10 years**	**Yes**	**No**
	Gain? (kg)		
	Loss? (kg)		
	Have you ever **smoked**?		
	If so, from when to when?		
	Do you currently smoke?		
	If so, what and how much?		
	Does it bother you if people smoke in your vicinity?		
	Are you hypersensitive to scents/perfume?		

MEDICAL HISTORY

A - PERSONAL MEDICAL HISTORY

	Do you have or have you had any of the following conditions?	**Yes**	**No**
	Children's / infectious / travel diseases		
	Parasites		
	Diphtheria		
	Pertussis (whooping cough)		
	Measles		
	Chicken pox		
	Rubella		
	Mumps		

	Tick bite (Lyme disease)		
	Mononucleosis		
	Hepatitis		
	Tuberculosis		
	Sexually transmitted diseases		
	Travel diseases		
	Infectious diseases		
	Other diseases, which?		
	Cardiovascular disease / diseases of the **nervous system** / **sensory organs / vascular systems**		
	High blood pressure		
	Low blood pressure		
	Heart disease		

	Do you have or have you had any of the following conditions? (Continued from Page 1)	**Yes**	**No**
	Vascular diseases, which?		
	Stroke		
	Rheumatism		
	Neurological and mental diseases		
	If so, which?		
	Seizures (epilepsy)		
	Eye diseases, which?		
	Ear diseases, which?		
	Vascular diseases, which?		
	Metabolic diseases		
	Diabetes		
	Elevated blood fat levels (cholesterol, triglycerides)		
	Elevated liver function test		
	Thyroid diseases, which?		
	Other metabolic diseases, which?		
	Urinary and sexually transmitted diseases		
	Bladder and kidney diseases, which?		
	Diseases of the **digestive organs**		
	Oral mucositis		
	Esophagitis		
	Gastritis/heartburn		
	Gastric/intestinal ulcer		
	Crohn's disease (ileitis terminalis)		
	Diverticulosis		
	Ulcerative colitis		
	Irritable colon		
	Gallbladder diseases / gallstones		
	Pancreatitis		
	Inguinal, incisional, and umbilical hernias		
	Liver diseases, which?		
	Respiratory diseases		
	Hay fever / allergic rhinitis		

	Sinusitis		
	Chronic bronchitis		
	Asthma / COPD		
	Pneumonia		
	Neoplastic diseases		
	Malignant tumor (cancer)? Which?		
	Benign tumor? Which?		
	Spinal diseases		
	Muscle disorders		
	Joint disorders		
	Cancer prevention – Have you ever had a cancer screening test?		
	If so, when was the last time (year)		
	Vaccinations (please attach a copy of your immunization record card)		
	Vaccination complications?		
	If yes, which?		
	Teeth		
	Gum disease		
	Dental root infection		
	Amalgam fillings, currently (number)		
	Amalgam fillings, previously (number)		
	Gold fillings		
	Other metals		
	Dental ceramics		
	Dead teeth		
	Root canal treatments		
	Dental posts		
	Dental implants		

	Do you have or have you had any of the following conditions? (Continued from Page 2)	**Yes**	**No**
	Crowns		
	Bridges		
	Denture (third set of teeth)		
	Braces, currently		
	Braces, previously		
	Removal of toxins, if so, which type and for how long?		
	Has a foreign material been embedded during a surgical procedure? (screw, splint, crib, etc.)		
	Allergy (if an allergy record card available, please attach a copy)		
	Do you suffer from allergies or allergy-like reactions?		
	If so, which?		

B - FAMILY MEDICAL HISTORY

	Family diseases: Do the following diseases run in your family? If so, in which family members? Please cross where applicable.	**Mother**	**Father**	**Siblings**	**Grand-mother maternal**	**Grand-father maternal**	**Grand-mother paternal**	**Grand-father paternal**
	Genetic disorders							
	Addiction							

	Intestinal diseases							
	Tuberculosis							
	Thyroid disease							
	Diabetes							
	Kidney disease							
	Adrenal gland disorders							
	Liver diseases							
	Cancer							
	Mental disorders							
	Tendency to be overweight							
	High blood pressure							
	Cardiovascular diseases							
	Osteoporosis							
	Allergies							
	Joint and muscle disorders							
	Seizures							
	Asthma							
	Eczema							
	Stroke							
	Other diseases							
	If so, which?							

C - GENERAL PHYSICAL HEALTH					
How do you generally feel (general condition)?	**Excellent**	**Good**	**Fair**	**Poor**	**Very poor**
Do you have any of the following **health symptoms?**	**No**	**Slight**	**Moderate**	**Strong**	**Very strong**
Drop in performance					
Lack of motivation					
Indifference					
Depressive mood / tendency to sorrowful brooding					
Impairment of concentration and memory					
Chronic fatigue					
Difficulty falling asleep					
Difficulty sleeping through the night					
Agitation, internal unrest					
Anxiety/panic states					
Feeling cold					
Hot flashes					
Night sweats					
Attack of sweating, at daytime and nighttime					
Lack of appetite					
Cravings					

	Do you have any of the following health symptoms (Continued from Page 3)	No	Slight	Moderate	Strong	Very strong
	Weight gain					
	Weight loss					
	Water retention					
	Lack of libido / erectile dysfunction					
	Susceptibility to infection					
	Cardiovascular symptoms					
	Vertigo or blackout					
	Heart palpitations					
	Racing heart					
	Chest tightness					
	Other cardiovascular symptoms					
	Which?					
	Urinary symptoms					
	Painful/burning urination					
	Frequent urination (more than once at night)					
	Involuntary discharge of urine spontaneously or when under stress					
	Other symptoms, which?					
	Respiratory symptoms					
	Dry cough (excluding colds or allergies)					
	Hoarseness (excluding colds or allergies)					
	Shortness of breath at rest					
	Shortness of breath during activities					
	Asthma attacks					
	Paranasal or frontal sinus symptoms					
	Nosebleed					
	Sensation of having a lump in one's throat					
	Burning throat and pharynx (excluding colds or allergies)					
	Congested nose, tearing eyes, etc. (hay fever-like symptoms)					
	Dry nose					
	Other respiratory symptoms, which?					
	Muscle and joint symptoms					
	Muscle fatigue					
	Muscle tremor					
	Muscle cramps					
	Strained or painful muscles					
	Strained or painful large joints					
	Strained or painful small joints					
	Joint swelling					
	Morning stiffness of joints					
	Pain/tension in neck/shoulder area					
	Back / lower back pain					
	Other joint/muscle symptoms					
	Which?					

	Symptoms of the nervous system and sensory organs					
	Neuralgia					
	Signs of paralysis					
	Numbness of extremities					
	Tingling/burning sensation, "pins and needles"					
	Headaches, migraine					
	Itchy eyes					
	Tearing eyes					
	Dry eyes					
	Visual impairments					
	Red or burning eyes					
	Disturbances of tactile sensation					
	Touch perception, increased					
	Touch perception, decreased					
	Temperature perception, increased					

	Do you have any of the following health symptoms (Continued from Page 4)	**No**	**Slight**	**Moderate**	**Strong**	**Very strong**
	Temperature perception, decreased					
	Vertigo					
	Tinnitus, buzzing/ringing in the ears					
	Earaches, pressure in the ears					
	Changes in the sense of smell					
	Impaired sense of taste					
	Other symptoms associated with the nervous system					
	Which?					
	Skin					
	Dry skin					
	Oily skin					
	Hypersensitive skin					
	Pigment changes in skin					
	Bruises					
	Itching					
	Acne					
	Fungal infection of skin, nails or feet					
	Impaired wound healing (poorly healing wounds)					
	Other skin symptoms					
	Which?					
	Hair and nail symptoms					
	Hair loss (head)					
	Reduced body hair / hair loss					
	Loss of eyelashes, brows, pubic hair, underarm hair					
	Oily hair					
	Increased body hair					
	Increased hair growth (head and face)					
	Nails break or split					

	Nails with spots, horizontal/vertical ridges, holes, lamella					
	Digestive symptoms					
	Cracked corners of mouth					
	Dry mouth					
	Bad breath					
	Changes in gum health					
	Increased salivary flow					
	Burning tongue					
	Difficulty swallowing					
	Increased thirst					
	Burping, heartburn					
	Food intolerance					
	Alcohol intolerance					
	Nausea					
	Vomiting					
	Bloating					
	Flatulence					
	Upper abdominal symptoms					
	Abdominal cramps					
	Constipation					
	Diarrhea					
	Anal itching/pain					
	Other digestive symptoms					
	Which?					
	How often do you have a bowel movement? (state number, mark applicable column)			**Per day**	**Per week**	**Per month**

	Have you been lately under particular **psychological stress**? Due to	**Yes**	**No**
	Relationship conflicts		
	Problems associated with the own children		
	Problems with parents/in-laws		
	Serious diseases		
	Death of a relative or spouse		

	Have you been lately under particular **psychological stress**? (Continued from Page 5)	**Yes**	**No**
	Other cases of death		
	Problems with work		
	Joblessness		
	Mobbing		
	Other psychological stress—which?		
	Do your symptoms change in certain environments or special rooms?	**Yes**	**No**
	If so—regularly?		
	In the past, have your symptoms been associated with		
	Specific toxin exposures		
	Other environmental factors		
	A certain environment		
	Traveling/vacation away from home		

	Do your symptoms change after returning from being away from home (e.g. vacation/weekend)?		
	Information regarding hobbies and sports		
	Hobbies		
	1.		
	2.		
	3.		
	Sports		
	1.		
	2.		
	3.		
	Which medications or supplements do you take / have you taken for a longer period of time—at minimum four weeks? (Please attach a copy of your dose schedule.)		
	Name/type	For	How much / when

	D - FEMALE HEALTH (to be filled out by women only!)		
	Previous history of menstrual cycle	**Yes**	**No**
	Irregularities Last period on:		
	Contraceptive methods		
	Birth control pill		
	Intrauterine spiral		
	Diaphragm		
	Condom		
	Chemical contraceptives		
	Tubal ligation		
	Gynecological diseases		
	If so, which?		
	Pregnancies/miscarriages		
	Have you ever been pregnant?		
	If so, how often?		
	Have you ever had a miscarriage?		
	If so, how many?		
	Do you have an unfulfilled desire to have children?		
	If so, please check with the office whether there is an additional specific questionnaire available.		
	Surgeries	**Yes**	**No**
	Surgeries in the abdominal area		
	Gynecological surgeries		
	If so, which, when?		
	Have you been diagnosed with endometriosis?		
	If so, have you received treatment and if so, which type of treatment:		

	Type of therapy:		
	Surgery		

	Surgeries (Continued from Page 6)	**Yes**	**No**
	Hormone therapy		
	Other therapies		
	Other surgeries		
	Other gynecological symptoms		
	If so, which?		
	Vaginal flow		
	Vaginal or vulval itching or burning		
	Pain during intercourse		
	Leaking breasts (outside of breastfeeding and pregnancy)		
	One side		
	Both sides		

D - MALE HEALTH (to be filled out by men only!)

	Surgeries/diseases in the abdominal area	**Yes**	**No**
	Have you been operated on your appendix?		
	If so, when?		
	Have you had intestinal surgery?		
	If so, when?		
	Other surgeries?		
	Urologic diseases		
	Which, when?		
	Prostate diseases		
	Have you had undescended testicles?		
	Have you had varicose or testicle surgery?		
	Have you had pelvic inflammatory diseases?		
	If so, which?		
	Have you been sterilized? (vasectomy)		
	Have you had a reversal vasectomy procedure?		
	Unfulfilled desire to have children		
	If so, please check with the office whether there is an additional specific questionnaire available.		

HOME ENVIRONMENT

A - LOCATION	**Now**			**In the past**		
In the questions below, please state approximate distances 1 = Immediate neighborhood 2 = Up to 500 m 3 = > 500 m – 1000 m	1	2	3	1	2	3
Green space						
Rural area						
Local recreational area						
Landfill site						
Bodies of water						

	Vineyards						
	Garbage incineration plant						
	Dry cleaning						
	Road with heavy traffic or highway						
	Agriculture						
	Commercial buildings						
	Airport / aircraft noise						
	Combined heat and power station						
	Noise pollution						
	High-voltage power line						
	Power cable / transformers / overhead transmission lines						
	RF transmitters / radar stations						
	Railroad						
	Nuclear power plant						

B - EXPOSURES		
	What have you been exposed to in your home/surroundings over the past 10 years?	Moving in month/year	Moving out month/year
	Current home (please mark with A)		
	Previous home (please mark in sequence with P1)		
	Previous home (please mark in sequence with P2)		
	Secondary home (please mark with S)		

C - BUILDING	Now A and/or S	In the past (P1 and/or P2)
	Aerated concrete		
	Concrete		
	Brick		
	Wood		
	Half-timbered construction		
	Brick construction		
	Unknown		
	Built in (year)		
	Last renovation (year)		
	Building height		
	Ground floor only		
	Flat roof		
	Single-family detached home		
	Multifamily building		
	On which floor do you live:		
	Basement floor		
	Ground floor		
	Top floor		
	Does/did your home have		
	Water damage		

	Storm damage		
	Flood damage		
	Fire damage		
	Size of home (square meter)		
	Number of fellow occupants		

	D - SPECIAL FEATURES			Now	In the past
+ ++ ++ ++ ++	Heat, e.g. overheated				
	Cold, e.g. no heating				
	Humidity	> 60%	< 40%		
	Mold				
	Continuous light exposure				
	Air-conditioning system				
	Air freshener (absorber)				
	Room fountain				
	Heating				
	Central heating system				
	Gas central heating system				
	Other central heating system				
	Electric storage heater				
	Stand-alone heater				
	Floor, wall or ceiling heating system				
	Masonry heater				
	Open fireplace				
	Please state the fuel:				
	Water treatment available				
	Domestic hot water supply				
	Drinking water pipes, state the age in years (0 = unknown)				
	Lead				
	Copper				
	Galvanized pipes				
	Others (which?)				

	Special features of home environment (Continued from Page 8)	**Now**	**In the past**
	Kitchen stove		
	Gas		
	Coal/briquette/coke		
	Microwave oven (cooking and heating)		
	Induction stove		
	Have you had any pest control treatments in your home?		

	If so, when was the last time?		
	Do you yourself use pesticides (insecticide sprays, powders, etc.)?		
	If so, when was the last time?		
	Dead plants?		
	When has your home been renovated the last time? Year:		
	Do you have pets or have you had pets in the last 10 years?	**Yes**	**No**
	Which (number) from to		

E - ROOMS	**Bed-room**	**Living room**	**Kitchen**	**Others**
All questions refer to the current home				
Size in square meter				
Duration of stay per day (hours)				
Exposed beams / wood surface areas (square meter)				
Of these treated with wood preservatives?				
None				
Small				
Large/all				
Unknown				
When was the treatment applied (year)?				
Which type of wood preservative (state name of product used)?				
Varnish				
Glaze				
Beeswax				
Unknown				
Wall/ceiling paneling made of plastic?				
None				
Small (e.g. beams)				
Moderate (e.g. ceiling/walls)				
Large (ceilings and walls)				
Subfloor				
Screed				
Particleboards				
Floorboards				
Flooring				
Laminate				
Floorboards				
Cork				
Wood flooring				
Plastic, e.g. PVC				
Linoleum				
Stone/tiles				
Carpeting/rugs				
If so, which material?				
Wool carpets or wall carpets / art carpets				

	Subfloor filling / floor insulation				
	Furniture				
	Plastic/particleboard furniture				
	None				
	Few (e.g. small furniture)				

	Room furnishings – (Continued from Page 9)	**Bed-room**	**Living room**	**Kitchen**	**Others**
	Many (almost all)				
	Leather furniture				
	None				
	Few (e.g. small furniture)				
	Many				
	Antique furniture				
	None				
	Which treatment applied (state name of product used)				
	Glaze				
	Varnish				
	Beeswax				
	Woodworm treatment				
	Hot air treatment				
	Age of wood furniture				
	New (up to 6 months)				
	Moderately old (up to 5 years)				
	Old (older than 5 years)				
	When treated with what (manufacturer/product)?				
	Varnish				
	Glaze				
	Beeswax				
	Oil				
	Water bed				

OCCUPATION / WORKPLACE / EDUCATION

	What is your occupation?		
	How long have you been working in this occupation? (years)		
	What occupation have you been working in the longest?		
	For how long in total? (years)		
	What occupation do you currently work in?		
	Since when (years)		
	What is manufactured?		
	Weekly working time (hours)		
	Night shift / shift work	Yes	No

	Other work / part-time work	Weekly hours	Since (year)
	1.		
	2.		
	3.		

If you are married or live together with a partner, what occupation does he or she work in?

Which type of environmental agents have you been exposed to at your workplace or educational institution in the last 10 years?

Has/had a job as	From	To

Description of the workplace:	Now	In the past
Weekly working hours (hours)		
Type of job		
Physical		
Mental		
Both		
Place of work:		
Outdoor		
Indoor		
Both		
Type of work		
Autonomous		
Temporary work		
Assembly line work		
Group work / multiple activity		
Multiple activity		

A - PERSONAL PROTECTION	Now / yes	Now / no	Past / yes	Past / no
Mask/protective goggles				
Gloves				
Shoes				
Head protection				
Ear protection				
Protective clothing				
Exhaust extraction system available				
Ventilation system available				
Others, if yes – which?				

B – WORKPLACE ENVIRONMENT	Now			In the past		
In the questions below, please state approximate distances 1 = Immediate neighborhood 2 = Up to 500 m 3 = > 500 m – 1000 m	1	2	3	1	2	3
Green space						
Rural area						
Landfill site						

	Bodies of water						
	Vineyards						
	Garbage incineration plant						
	Dry cleaning						
	Road with heavy traffic or highway						
	Agriculture						
	Commercial buildings						
	Local recreational area						
	Airport / aircraft noise						
	Combined heat and power station						
	Noise pollution						
	High-voltage power line						
	Power cable / transformers / overhead transmission lines						
	RF transmitters / radar stations						
	Railroad						
	Nuclear power plant						

C - BUILDING		
Aerated concrete		
Concrete		
Brick		
Wood		
Half-timbered construction		
Brick construction		
Unknown		
Built in (year)		
Location of workplace		
Large city / city		
Suburb		
Residential area		
Industrial/commercial area		
Mixed area		
Small town		

	Are you / have you been exposed to particular chemical, physical, or other stressors? (Intensity 1-6 / 1 = low, 6 = high)			In which context?	
		Yes	No	Private	Occu-pation-al
	Heat				
	Cold / air-conditioning system				
	Humidity / mold growth				
	Video display terminals / screens				
	Noise, e.g. computer, printer				
	Mental stress				
	Artificial lighting				
	Continuous light exposure				
	Copier / laser printer / ink-jet printer				
	Solvents / cleaning agents / adhesives				
	Odor pollution				
	Hair care products, incl. professional products				
	Makeup products				
	Dry cleaned clothes				
	Leather (furniture, clothes, etc.)				
	Metals (nickel, etc.)				
	Insecticides, pesticides, herbicides (weed killer, pest control agents)				
	Pest control treatments at home or at work				
	Radioactive substances or radiation				
	Do you assume that pollutants or environmental factors cause your symptoms?				
	If so, which?				

	D – SPECIAL FEATURES - WORKPLACE	**Now**	**In the past**
	Exposed beams / wood surface areas in square meter		
	Of these treated with wood preservatives?		
	None		
	Small		
	Large/all		
	Unknown		
	Wall/ceiling paneling made of plastic?		
	Flooring		
	Laminate		
	Floorboards		
	Cork		
	Wood flooring		
	Plastic, e.g. PVC		
	Linoleum		
	Stone/tiles		
	Wall-to-wall carpeting		
	Carpet		
	Furniture		

	Plastic/particleboard furniture		
	None		
	Few (e.g. small furniture)		
	Many (almost all)		
	Computer/copier/Wi-Fi/phone		
	Number of computers in your working space		
	Duration of working hours at computer (hours per day)	Occupational	Private
	Copier / laser printer / ink-jet printer in working space		
	DECT cordless phone		
	Wi-Fi at workplace		
	Are or were **pest control treatments** regularly applied at your workplace?		
	When was the last time?		

	Special features – Work environment (Continued from Page 12)	**Now**	**In the past**
	Do you yourself use **pesticides** at your workplace?		
	If so, which?		
	Does the Toxic Substance Regulation or other special safety regulations apply to your workplace?		
	If so, which?		
	Please describe in your own words your work / workplace (please use an additional page if necessary):		

NUTRITION

	I eat/drink without restrictions	**Yes**	**No**
	Anything		
	Vegetarian:		
	Lacto vegetarian		
	Ovo-lacto vegetarian		
	Vegan		
	Other forms of nutrition		
	Do live on **organic** food?		
	Established **primary diseases with a connection to nutrition**		
	Lactose intolerance		
	Fructose malabsorption		
	Verified food allergies		
	Gluten intolerance		
	Celiac disease		
	Diabetes		
	Gout		
	Histamine intolerance		

	Other verified metabolic disorders		
	Do you currently follow a **special course of treatment** recommended by your physician or for personal reasons? If so, which?		
	Are there certain foods that you do not tolerate? If so, which?		

DIETARY HABITS

	In the questions below, please state your **average weekly** consumption, **reflecting the intake of the last 12 months**.	Do **not** eat/ drink	Once per week	2-3 times per week	4-6 times per week	Daily Once	Daily 2-3 times	Daily More than 4 times
	Meat (pork, beef, lamb, poultry, game)							
	Eggs							
	Mussels, shellfish or crustaceans							
	Bread, buns (1 slice or 1 piece)							
	White bread							
	Rye or spelt bread							
	Sausage, ham (slice)							
	Butter							
	Margarine							
	Lard, other animal fats							
	Vegetable (cooked or raw)							
	Lettuce							
	Fresh fruit							

	In the questions below, please state your **average weekly** consumption, **reflecting the intake of the last 12 months**.	Do **not** eat/ drink	Once per week	2-3 times per week	4-6 times per week	Daily Once	Daily 2-3 times	Daily More than 4 times
	Chocolate, sweets							
	Cakes, cookies							
	Ready-to-eat or canned meals							
	Fast food							
	Restaurant food							
	Salad dressing with oil, which?							
	Vinegar							
	Mayonnaise							
	Ready-to-eat dressing							
	Grains, pasta, potatoes and other starchy foods							
	Rolled oats, muesli, cornflakes, etc.							
	Noodles and other pasta							
	Potatoes							
	Rice							
	Dairy products							
	Milk							

	Cacao							
	Yogurt/kefir							
	Hard cheese							
	Soft cheese							
	Curd, cottage cheese, cream cheese							
	Cream, crème fraiche							
	Soy milk							
	Fruit (piece or portion)							
	Apple							
	Banana							
	Orange, mandarin, grapefruit, lemon							
	Stone fruit							
	Grapes							
	Strawberries							
	Other berries							
	Pineapple, mango, kiwi, melon, other tropical fruit							
	Nuts							
	Beverage (glass/cup)							
	Coffee							
	Tea							
	Fruit juice							
	Lemonade							
	Coca-Cola or the like							
	Beer							
	Wine, champagne							
	Other alcoholic beverages							
	Require additional information regarding the following points:							
	For scientific purposes, we would like to analyze your **anonymized data**. For that, we require **your consent.**							
	I give my consent.							
	Date:	Signature						