



Toxin Exposure Questionnaire

Patient Name _____ Date _____

Please check the best response for each of the following questions. Your provider will discuss your answers with you.

FOOD & WATER	YES	SOMETIMES	IN THE PAST	NO
1. Do you consume conventionally-farmed (non-organic) or genetically-modified fruits and vegetables?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you consume conventionally-raised (non-organic) animal products (i.e., meat, poultry, dairy, eggs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you consume canned or farmed fish and seafood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you consume processed foods (i.e., foods with added artificial colors, flavors, preservatives, or sweeteners), deep-fried, or fast foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you drink water from a well, spring, or cistern, or from plumbing pipes or fixtures installed before 1986?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you drink sodas, juices, or other beverages with natural or refined sweeteners (i.e., high-fructose corn syrup, cane sugar, agave nectar, Stevia, undiluted fruit juice, etc.) or artificial sweeteners (i.e., NutraSweet/Equal/aspartame, Sweet 'N Low/saccharine, Splenda/sucralose, Sunett/Sweet One/acesulfame K, neotame)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOME & WORK ENVIRONMENT	YES	SOMETIMES	IN THE PAST	NO
1. Do you live in an apartment or home built before 1978, or in a mobile home, boat, or RV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your home or workplace contain new construction materials or furniture (i.e., paint, laminate flooring, particle board, new carpeting, bedding, furniture, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your home or workplace show signs of mold or water damage (i.e., cracking paint, ceiling leaks, decaying insulation or foam, visible mold, or damp windows, basement, or crawlspaces, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you exposed to toxic substances (i.e., treated lumber, lead paint, paint chips or dust, broken mercury thermometers or fluorescent bulbs, etc.) at home or work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you exposed to conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you live or work near an industrial pollution source (i.e., highway, factory, incinerator, gas station, power plant, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you live or work near a source of electromagnetic radiation (i.e., cell phone tower, high-voltage power lines, or other known source)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you live or work in an agricultural area or another type of area where you are exposed to herbicides, pesticides, or fungicides?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have wood-burning, propane, or gas stoves or appliances at home or work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you live or work in a sealed building with recirculated air?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TRAVEL & RECREATION	YES	SOMETIMES	IN THE PAST	NO
1. Do you frequent parks, golf courses, or other outdoor or recreational areas treated with herbicides, pesticides, or fungicides?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you travel by air?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you run or bike to work along busy streets?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you get sick while camping, hiking, or traveling (foreign or domestic)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you exposed to toxic chemicals as a result of a hobby (i.e., paints, photo-developing chemicals, epoxy adhesives, glues, varnishes, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL & PERSONAL CARE	YES	SOMETIMES	IN THE PAST	NO
1. Are you sensitive to personal care products like lotions, moisturizers, toners, shampoos, conditioners, shaving creams, and soaps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you smoke, or are you often exposed to second-hand smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a history of heavy use of alcohol, or recreational or prescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any unusual reactions to anesthesia or to prescription or over-the-counter medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have root canals, extracted teeth, "silver" fillings, crowns, dental sealants, dentures, retainers, aligning trays, braces, mouth guards, dental implants, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any artificial materials in your body (implants, pins, joints, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you lead a high-stress lifestyle, or have you experienced a stressful or traumatic event?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>