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Toxicity Assessment

General Toxicity

Have you ever smoked or been exposed to 3rd party smoking?	Yes	No
Have you ever lived near on or by a golf course, freeway or tension wires?	Yes	No
Have you ever had any chemical exposure? (cleaning, chemical spill, beauty salon)	Yes	No
Do you have your house sprayed with pesticides for pest control?	Yes	No
Do you spray herbicide (weed killer) in or around your house?	Yes	No
Do you or your family use conventional insect repellents?	Yes	No
Do you use conventional sunscreen?	Yes	No
Do you use conventional perfume/cologne every day?	Yes	No
Do you get your hair colored? If so, is it on the scalp?	Yes	No
Do you use aerosol hairspray?	Yes	No
Do you get your nails done? If so, how often?	Yes	No
Do you use air fresheners in your house, work or car?	Yes	No
Does your spouse or family members work around chemicals?	Yes	No
Do you have breast implants?	Yes	No
Have you ever had breast implants removed?	Yes	No

Can you think of any other toxic exposure you may have had?

_____

_____

_____

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Mercury

Do you have amalgam (silver) fillings in your teeth?	Yes	No
Have you ever had amalgam fillings removed?	Yes	No
If so, was it done by a biological dentist using a safe protocol?	Yes	No
Have you had any dental crowns? If so, how many? _____	Yes	No
Have you ever worked in a dental office?	Yes	No
Have you had any bridges?	Yes	No
Have you had any root canals?	Yes	No
Have you had any tooth extractions?	Yes	No
Do you have any dental implants, retainers, or other metal in your mouth?	Yes	No
Did you wear contact lenses in the 1980's or early 1990's?	Yes	No
Did you take oral contraceptives during the 1980's or early 1990's?	Yes	No
Did you receive yearly flu shots?	Yes	No
Have you received a recent flu shot, allergy shot, or vaccination?	Yes	No
Do you have any tattoos with red ink?	Yes	No
Do you eat large amounts (more than 2x/week) of tuna, shark swordfish or Atlantic salmon?	Yes	No

Mold

How old is the house you are living in? _____

How long have you lived there? _____

Have you noticed any symptoms since moving in?	Yes	No
Do you see mold growing at home, work, or school?	Yes	No
Have you ever had water damage at home/work/school?	Yes	No

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Mold cont.

Does your home/workplace/school have a damp or mildew smell?	Yes	No
Does spending time in your basement worsen symptoms?	Yes	No
Does your basement ever get wet?	Yes	No
Do you have a crawl space?	Yes	No
Does spending time in a different location for a few days cause a noticeable decrease in your symptoms?	Yes	No
Does your car have a mildew smell?	Yes	No
Does anyone in your home have asthma-like symptoms?	Yes	No
Does anyone in your home have chronic sinus infections or irritations?	Yes	No

Please explain your housing history (type of homes, where and when) :

_____
_____
_____
_____
_____
_____

Lead

Does your occupation involve soldering or metal salvage?	Yes	No
Have you done any old home repairs or sandblasting?	Yes	No
Do you do a lot of painting?	Yes	No
Was your home built before 1978?	Yes	No
Have you ever worn cosmetics containing kohl (dark black/red pigment makeup)	Yes	No
Are you around a lot of fake leather or vinyl?	Yes	No
Do you get stomach aches in the morning?	Yes	No

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Lyme

Have you ever been diagnosed with Lyme disease?	Yes	No
Have you ever had dry sockets or infected tooth extractions?	Yes	No
Do you have small joint paint?	Yes	No
Have you ever been bitten by a tick, recluse spider, or any other insect with a bullseye or rash afterward?	Yes	No
Have you ever seen a bulls-eye rash appear anywhere on your body?	Yes	No
Have you ever noticed any other type of rash occurring?	Yes	No

If so, when?
Please describe (how it felt/looked) –

_____
_____
_____

Was your mother ever diagnosed with Lyme disease?	Yes	No
Do you frequently go camping, hiking, or involved in outdoor activities? *(specifically wooded or grassy areas)*	Yes	No