FUMIGANT EXPOSURE QUESTIONNAIRE

Fum-Ex1

STUDY SITE (INSTITUTION) _____

CO-INVESTIGATOR _____

DATE OF EVALUATION ___/___/_____

NAME-ACRONYM/or Nr. _____

DATE OF BIRTH ___/___/_____ **(MONTH/DAY/YEAR) or AGE** ___ **YEARS**

SEX F___ **M** ___

HEIGHT (cm) _____

WEIGHT (kg) _____

CURRENT SMOKER: YES ___ **NO** ___ **NEVER SMOKED** ___

WHEN DID YOU START SMOKING? DATE: ___/___/_____ **(MONTH/ YEAR)**

EX-SMOKER: YES ___ **NO** ___

DATE QUIT: ___/___/_____ **(MONTH/ YEAR)**

SMOKING HISTORY # CIGARETTS ___ **per DAY**

OCCUPATIONAL HISTORY

1. **JOB DESCRIPTION** _____
2. **SINCE WHEN ARE YOU WORKING IN YOUR CURRENT JOB?**
   ___ **(M)/** _____ **(Y)**

3. **DO YOU HAVE CURRENTLY CONTACT WITH FUMIGANTS, PESTICIDES OR OTHER TOXIC CHEMICALS ?**
   YES ___ **NO** ___
4. **REGULARY? YES** ___ **NO** ___
5. **IF YES TO QUESTION # 3, SPECIFY:** ___ **Methyl bromide (Bromomethane)**

   ___ **Ethylene dichloride (1,2 Dichloroethane)**

   ___ **Methylene chloride (Dichloroethane)**

   ___ **Phosphine**

   ___ _____ **(OTHER)**

   ___ _____ **(SOLVENTS)**

I. DURATION OF EXPOSURE IN TOTAL _____ (MONTHS)

II. HOW MANY HOURS DO YOU HAVE CONTACT WITH THE AGENTS MENTIONED ABOVE PER WEEK? ___ HOURS

III. WHEN WAS THE LAST EXPOSURE? ___/___/_____ (MONTH/DAY/YEAR)

IV. DURATION OF LAST EXPOSURE ____ (DAYS) ____ (HOURS) ____ (MINUTES)

6. IF NO (QUESTION # 3): DID YOU WORK WITH THESE AGENTS IN THE PAST?

YES ___ NO ___

WHICH AGENT? _____

WHAT WAS YOUR JOB DESCRIPTION AT THAT TIME? _____

EXPOSURE STARTED (DATE) ___/_____ (MONTH/YEAR)

EXPOSURE ENDED (DATE) ___/_____ (MONTH/YEAR)

7. WHILE WORKING DID YOU USE ANY PROTECTION EQUIPMENT? YES ___ NO ___

IF YES: WHICH? _____

8. SYMPTOMS

HOW MANY TIMES DID THE FOLLOWING SYMPTOMS OCCUR DURING OR AFTER WORK IN THE LAST 12 MONTHS?

SYMPTOMS/INCIDENCE	ALMOST ALWAYS	OFTEN	SPORADIC	ALMOST NEVER	NEVER	WHEN DID IT OCCURE FOR THE FIRST TIME? (M/D/Y)
HEADACHE	I_I	I_I	I_I	I_I	I_I	___/___/_____
DIZZINESS	I_I	I_I	I_I	I_I	I_I	___/___/_____
AIRWAYS IRRITATION, COUGH	I_I	I_I	I_I	I_I	I_I	___/___/_____
MUCOSA IRRITATIONS (EYE ITCHING, RHINITIS,STOMATITIS)	I_I	I_I	I_I	I_I	I_I	___/___/_____
SKIN IRRITATION	I_I	I_I	I_I	I_I	I_I	___/___/_____
NAUSEA	I_I	I_I	I_I	I_I	I_I	___/___/_____
DIZZINESS	I_I	I_I	I_I	I_I	I_I	___/___/_____
MUSCLE CRAMPS	I_I	I_I	I_I	I_I	I_I	___/___/_____
CONCENTRATION DISORDERS	I_I	I_I	I_I	I_I	I_I	___/___/_____
DYSGUSIA Distortion sense of taste	I_I	I_I	I_I	I_I	I_I	___/___/_____
NUMBNESS	I_I	I_I	I_I	I_I	I_I	___/___/_____
DIARRHEA, ABDOMINAL CRAMPS	I_I	I_I	I_I	I_I	I_I	___/___/_____
WEAKNESS, FATIGUE	I_I	I_I	I_I	I_I	I_I	___/___/_____
SEIZURES	I_I	I_I	I_I	I_I	I_I	___/___/_____
DISTURBANCE OF MEMORY	I_I	I_I	I_I	I_I	I_I	___/___/_____
CHEST TIGHTNESS, DYSPNEA	I_I	I_I	I_I	I_I	I_I	___/___/_____
EMOTIONAL INSTABILITY	I_I	I_I	I_I	I_I	I_I	___/___/_____
SLURRED SPEECH	I_I	I_I	I_I	I_I	I_I	___/___/_____
SLEEP DISORDER	I_I	I_I	I_I	I_I	I_I	___/___/_____
IMPAIRED BALANCE,	I_I	I_I	I_I	I_I	I_I	___/___/_____

DISTURBED GAIT						
TREMOR	I_I	I_I	I_I	I_I	I_I	___/___/_____

10. HAVE YOU EXPERIENCED INCREASED COUGH WHILE WORKING? YES ___ NO ___

11. HAVE YOU EXPERIENCED INCREASED AIRWAYS IRRITATIONS WHILE WORKING?
    YES ___ NO___
12. HAVE YOU EVER BEEN UNCONSCIOUS IN THE LAST YEARS? YES ___ NO ___
13. IF YES (QUESTION #10): DID IT HAPPEN AT YOUR WORKPLACE? YES ___ NO ___
14. PLEASE INDICATE BELOW WHICH CHRONIC OR ACUTE CONDITION(S) YOU HAVE:
    I_I ARTHRITIS, SPECIFY _____
    I_I RHEUMATIC DISEASE, SPECIFY _____
    I_I ASTHMA, SPECIFY _____
    I_I CANCER, SPECIFY _____
    I_I DIABETES, SPECIFY _____
    I_I KIDNEY DISEASE, SPECIFY _____
    I_I LIVER DISEASE, SPECIFY _____
    I_I OTHER CHRONIC CONDITION, SPECIFY _____
    _____
15. ARE YOU CURRENTLY TAKING ANY MEDICATION? YES ___ NO ___
    IF YES, SPECIFY: _____

16. DID YOU HAD CONTACT TO GENOTOXIC AGENTS?

    YES ___ NO ___

    WHICH AGENT? _____
17. HAVE YOU BEEN EXPOSED TO IONIZING RADIATION FOR DIGNOSTIC PURPOSES?

    YES ___ NO ___

    HOW LONG?_____

18. ADDITIONAL INFORMATION IF NEEDED: _____

    _____

    _____

THANK YOU VERY MUCH FOR YOUR COOPERATION!