

PATIENT NAME _____ DATE: _____

ENVIRONMENTAL SURVEY

GENERAL

1. Do you live in a house apartment other _____
2. Is this a brick frame other type of construction.
3. How old is your home? _____
4. Do you have central heating and cooling? yes no How often do you change the air filters? _____
5. Do you use ceiling fans? yes no
6. Is there a damp or musty smell in areas of the house? yes no
7. Circle if you have contact with the following on a regular basis (mark 'I' if allowed inside):
 Cat ___ Dog ___ Bird ___ Hamster/Gerbil ___ Rabbit ___ Aquarium ___ Farm Animals ___
8. Do any household family members smoke? Self Father Mother Spouse Child
 Is there any other significant exposure to smoke? yes no _____

PATIENT'S BEDROOM

1. Is the bedroom shared with another? yes no
2. Is this room carpeted? yes no
3. Check all applying to bedding: Bunk bed Canopy Bed Water Bed Comforter
 Mattress **encased** in plastic Feather pillow - age: _____
4. Check all that apply to the window treatments in the bedroom: Shades Curtains
 Venetian blinds/miniblinds Shutters Other _____
5. Check the following items that are in the bedroom: fan stuffed animals house plants
 upholstered furniture humidifier/vaporizer wallpaper
6. How often is the bedroom Vacuumed _____ Dusted _____ by whom _____
7. Other comments about the home/household:

8. Do you have a second home yes no : if yes, do you have problems there? no yes (explain)

Work Environment (Complete this section if patient is an adult)

1. Do you have potential exposure to unusual chemicals no yes (describe if yes):

2. Are symptoms better worse at work?
3. Does your spouse have exposure to unusual chemicals ? No Yes (describe if yes):

Complete This Section If Patient Is A Child

1. Is there potential exposure to **pets** No Yes, **smoke** No Yes, **other** _____
 (describe if yes) _____
2. Does the Father Mother have exposure to chemicals? Explain _____
3. Are symptoms better worse at school/daycare?
4. If in Day Care, how many day per week? _____ How many children in their class? _____

Signature patient/parent

Doctors Signature