



Fum-Ex 2

FUMIGANT EXPOSURE QUESTIONNAIRE

STUDY SITE (INSTITUTION) _____

CO-INVESTIGATOR _____

DATE OF EVALUATION ___/___/_____

NAME-ACRONYM/or Nr. _____

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

SEX F___ M___

HEIGHT (cm) _____

WEIGHT (kg) _____

CURRENT SMOKER: YES ___ NO ___ NEVER SMOKED ___

EX-SMOKER: YES ___ NO ___

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

SMOKING HISTORY IN # OF PACK YEARS: ___ PACK-YEARS

OCCUPATIONAL HISTORY

1. JOB DESCRIPTION _____

2. SINCE WHEN ARE YOU WORKING IN YOUR CURRENT JOB?

___ (M)/ _____ (Y)

3. DO YOU CURRENTLY WORK WITH FUMIGANTS, PESTICIDES OR OTHER CHEMICALS?

YES ___ NO ___

4. IF YES TO QUESTION # 3, SPECIFY: ___ Methyl bromide

___ Ethylene dichloride

___ Methylene chloride

___ Phosphine

___ _____ (OTHER)

I. DURATION OF EXPOSURE IN TOTAL _____ (MONTHS)

II. HOW MANY HOURS DO YOU WORK 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)

5. 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)

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

IF YES: WHICH? _____

7. Did YOU had contact to genotoxic agents?

YES ___ NO ___

WHICH AGENT? _____

8. Have YOU been exposed to ionizing radiation for dignostic purposes?

YES ___ NO ___

How long? _____

9. SYMPTOMS

HOW MANY TIMES DID THE FOLLOWING SYMPTOMS OCCUR DURING THE LAST 12 MONTHS?

SYMPTOMS/INCIDENCE	ALMOST ALWAYS	OFTEN	SPORADIC	ALMOST NEVER	NEVER	WHEN DID IT OCCURE FOR THE FIRST TIME? (M/D/Y)	WAS IT WORK-RELATED? YES/NO
HEADACHE	_	_	_	_	_	_ / _ / _	
CHEST TIGHTNESS, DYSPNEA	_	_	_	_	_	_ / _ / _	
AIRWAYS IRRITATION, COUGH	_	_	_	_	_	_ / _ / _	
MUCOSA IRRITATIONS (RHINITIS, STOMATITIS)	_	_	_	_	_	_ / _ / _	
EYE IRRITATION, CONJUNCTIVITIS	_	_	_	_	_	_ / _ / _	
NAUSEA	_	_	_	_	_	_ / _ / _	
DIZZINESS	_	_	_	_	_	_ / _ / _	
MUSCLE CRAMPS	_	_	_	_	_	_ / _ / _	
CONCENTRATION DISORDERS	_	_	_	_	_	_ / _ / _	
DYSGEUSIA	_	_	_	_	_	_ / _ / _	
NUMBNESS	_	_	_	_	_	_ / _ / _	
DIARRHEA, ABDOMINAL CRAMPS	_	_	_	_	_	_ / _ / _	
WEAKNESS, FATIGUE	_	_	_	_	_	_ / _ / _	
SEIZURES	_	_	_	_	_	_ / _ / _	
DISTURBANCE OF						_ / _ / _	

DISTURBANCE OF MEMORY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
SYMPTOMS/INCIDENCE	ALMOST ALWAYS	OFTEN	SPORADIC	ALMOST NEVER	NEVER	WHEN DID IT OCCURE FOR THE FIRST TIME? (M/D/Y)	WAS IT WORK-RELATED? YES/NO
EMOTIONAL INSTABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
SADNESS, DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
SLEEP DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
IMPAIRED BALANCE, DISTURBED GAIT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
TREMOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	
OTHER, PLEASE SPECIFY _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	

10. HAVE YOU EVER BEEN UNCONSCIOUS IN THE LAST YEARS? YES ___ NO ___

11. IF YES (QUESTION #10): DID IT HAPPEN AT YOUR WORKPLACE? YES ___ NO ___

12. PLEASE INDICATE BELOW WHICH CHRONIC OR ACUTE CONDITION(S) YOU HAVE:

ARTHRITIS, SPECIFY _____

RHEUMATIC DISEASE, SPECIFY _____

ASTHMA, SPECIFY _____

CHRONIC BRONCHITIS _____

CANCER, SPECIFY _____

DIABETES, SPECIFY _____

KIDNEY DISEASE, SPECIFY _____

LIVER DISEASE, SPECIFY _____

CENTRAL/PERIPHERAL NERVOUS SYSTEM DISEASE, SPECIFY _____

OTHER CHRONIC CONDITION, SPECIFY _____

13. ARE YOU CURRENTLY TAKING ANY MEDICATION? YES ___ NO ___

IF YES, SPECIFY: _____

14. DID YOU HAD CONTACT TO GENOTOXIC AGENTS?

YES ___ NO ___

WHICH AGENT? _____

WHEN? _____

15. HAVE YOU BEEN EXPOSED TO IONIZING RADIATION FOR DIGNOSTICOR THERAPEUTIC PURPOSES?

YES ___ NO ___

WHEN? _____

HOW LONG? _____

16. DIET

MEAT

HOW MANY TIMES PER WEEK? _____

VEGETABLES

HOW MANY TIMES PER WEEK? _____

FRUITS

HOW MANY TIMES PER WEEK? _____

ALCOHOL CONSUMPTION

WINE _____ **BEER** _____ **HIGH% SPIRITS** _____

HOW MANY TIMES PER WEEK? _____

17. ADDITIONAL INFORMATION IF NEEDED: _____

THANK YOU VERY MUCH FOR YOUR COOPERATION!