bioclinic naturals

ENVIRONMENTAL EXPOSURE QUESTIONNAIRE

A Metabolism of pollutants

1	Do you often have to lower the regular dose of prescription, over-the-counter medication, or herbal supplements because you are too sensitive to normal doses?	Yes	No
2	Do you need to avoid caffeine in the afternoon because it can keep you up at night?	Yes	No
3	Have you ever experienced adverse reactions to medications? If so, describe the medication and what the reaction was.	Yes	No

B Toxicant-related health problems

1	Do you often experience a sudden onset of physical, mental, or emotional symptoms upon exposure to chemical odours such as cleaners, perfumes, new materials, cigarette smoke, diesel exhaust, etc. Examples of symptoms include headaches, skin rashes, nausea, fatigue and shortness of breath.		Yes	No
2	When did you first notice such reactions?			
3	What was the chemical you first reacted to?			
4	Do you experience unpleasant symptoms when you walk down the soap aisle in the grocery store, or do you find yourself avoiding the soap aisle altogether?		Yes	No
5	In the last 6 months, are your chemical reactions getting better, worse or the same?	Better	Worse	Same

6 Tick the chemicals that you react to or are sensitive to and approximate age when it began.

	Age		Age		Age
Cleaners		Paints		Other (list)	
Perfumes		New carpet or fabric			
Cigarette smoke		Plastics			
Car exhaust fumes		Pesticides or other agricultural chemicals			

7 Please tick any illness that you have, or have had in the past, and note the age at which it began or became significantly worse.

	Yes?	Age		Yes?	Age
Asthma			Brain fog/diminished cognition		
Allergies			Memory loss		
Hypothyroidism			Depression or anxiety		
Infertility			Parkinsonism		
Low testosterone			Tremors		
Gestational hypertension			Rheumatoid arthritis		
Gestational diabetes			Lupus (SLE)		
Type 2 diabetes			Sjogren's syndrome		
Obesity			Autoimmune thyroiditis		
Balance disorder			Any other autoimmune illness		

C AIR POLLUTANT EXPOSURE

How many minutes drive, do you live from:		1-4	5-9	10-19	20-30	>30	Don't know
1	The closest highway or freeway?						
2	A busy street?						
3	The closest golf course?						
4	The closest agricultural area?						
5	The closest industrial area where you see smokestacks?						
6	The closest landfill?						

7	Do you live in a city, town or region known for its air pollution? If so, please state where it is.					Yes	No
	Please provide further details if you have previously lived in an area known for air pollution, or frequently travel to such areas.						
8	How often can you 'see the air' in your area?	All of the time	Most of the time	1-4 times monthly	4-8 times yearly	Rarely	
9	Approximately what year, or decade, was your house built in?						
10	Do you have air purifiers in your home?	Ozone				Yes	No
		Ion generator				Yes	No
		HEPE air purifier				Yes	No
		IQ Air or multifilter purifier				Yes	No
11	When were your air ducts last cleaned?						
12	Do you use spray or plug-in air-conditioners in the home?					Yes	No
13	Are shoes worn in the house?					Yes	No
14	Are pesticides used in your home or garden?					Yes	No
15	Do you have pets in your home that you apply anti-flea or tick product to?					Yes	No
	If so, how often?	Daily	Weekly	Monthly	< 1 Monthly		
16	Do you have an attached garage that your car is parked in?					Yes	No
17	Do you drive a diesel vehicle?					Yes	No
18	Does your car have an exhaust leak?					Yes	No
19	Type of appliances (stove, hot water)	Electric				Yes	No
		Natural gas				Yes	No

20	Type of heating	Electric	Yes	No
		Gas	Yes	No
		Oil	Yes	No
		Wood	Yes	No
		Diesel	Yes	No
21	Have you lived in a new home or recently remodelled home?		Yes	No
22	Does your current home have wall to wall carpets		Yes	No
23	Are the carpets treated with 'Scotchgard' or similar to resist staining?		Yes	No
24	Is any furniture or curtains treated with 'Scotchgard' or similar to resist staining?		Yes	No
25	Do you use Teflon coated cookware?		Yes	No
26	What is the newest piece of furniture in your home and when was it purchased?			
27	Do you sleep with any of the following?			
	• Pillow-top mattress		Yes	No
	• Memory foam mattress		Yes	No
	• Memory foam pillow		Yes	No
28	Do you have any hobbies that require the use of solvents, paints, gasoline or lead?		Yes	No
29	Have you ever worked at a job or did you attend schooling that brought you in contact with industrial chemicals? What chemicals?		Yes	No

	How many years?	1-4	5-9	10-19	20-30	>30

30	How often do you have your clothes dry cleaned?		
31	How often do you get your hair coloured?		
32	How often do you have your nails done (where an acrylic service is offered)?		

D METAL EXPOSURE

1	Were you raised in a smoking household?	Yes	No
2	Have you ever smoked?	Yes	No
	a) How many packs a day?		
	b) How many years?		
3	Have you lived in a home that was built before 1970?	Yes	No
4	Have you remodelled a home that was built before 1970?	Yes	No

5	Do you use filtered water for cooking and drinking?	Yes	No
6	Have you ever had silver amalgam fillings in your teeth?	Yes	No
	a) Do you grind your teeth?	Yes	No
	b) Total number of amalgams?		
	c) How many years have the amalgams been in your mouth?		
	d) If amalgams have been removed, how long ago?		
7	How often do you consume tofu?		

E FOOD POLLUTION

	How often do you consume the following foods?	Rarely/ never	< 1 x weekly	1 x weekly	> 1 x weekly
1	Tuna (canned)				
	Tuna (fresh)				
	Salmon (canned or farmed)				
	Salmon (wild)				
	Swordfish				
	Shark (flake)				
	Orange roughy				
	King mackerel				
	Barramundi				
	Sardines				
2	How often do you consume commercial varieties (non-organic) of the following?	Rarely/ never	< 1 x weekly	1 x weekly	> 1 x weekly
	Apples				
	Celery				
	Cherry tomatoes				
	Cucumber				
	Grapes				
	Nectarines				
	Peaches				
	Potatoes				
	Snap peas				
	Spinach				
	Other dark green leafy vegetables				
	Strawberries				
	Capsicum				
3	How often do you consume canned soup?				
4	How often do you have other canned foods?				
5	How often do you have pre-packaged ‘microwave-safe’ meals?				
6	How often do you microwave food in ‘microwave-safe’ plastic, or Styrofoam?				

F MYCOTOXINS

1. Have you ever had any of the following in your current or past residence?	Current residence		Past residence	
	Yes	No	Yes	No
Has your house ever flooded?				
Roof leaks?				
Window leaks?				
Water in the basement?				
Broken water pipe?				
Does your carpet ever get wet when it rains?				
Any water stains on ceilings or walls?				
Any rooms in the home that smell musty?				
Do you suspect that your home has mould in it?				
Is there any visible mould around the shower/ tub/ sinks in your home?				
Is there any visible mould on the walls or ceiling in your home?				
Do you have a front-loading washing machine?				
Ever received insurance money for your home?				
Ever needed assistance to clear water from your home?				
Is your home water supply from a well or cistern?				

G LIFESTYLE POLLUTANTS

1	How often do you use the following personal care products?	**Rarely/ never**	**< 1 x weekly**	**Daily**	**> 1 x daily**
	a) Skin lotion				
	b) Sunscreen				
	c) Scented deodorant				
	d) Perfume or cologne				
2	Do you have any silicone-containing implants?			Yes	No
	How many years have you had the implants?	1-4	5-9	10-19	20-30
3	Do you have implants of any other materials?			Yes	No
	How many years have you had the implants?	1-4	5-9	10-19	20-30
4	In your home do you have any of the following:				
	a) Wi-Fi routers			Yes	No
	b) Bluetooth appliances			Yes	No
	c) Smart meter			Yes	No
	d) Cordless phones			Yes	No
5	How many hours do you spend on a mobile phone a day on average?				