PATIENT PESTICIDE EXPOSURE HISTORY FORM

Name (First, Last): _____ Age: _____ Date: _____

SECTION 1. PESTICIDES AT WORK

1. What is your job(s)? _____
2. How long have you been doing this job(s)? _____
3. Describe your daily tasks:

   _____

4. Do you work where pesticides are applied? ☐ No ☐ Yes
5. Have you, yourself, applied pesticides as part of your job(s)? ☐ No ☐ Yes
6. Do you use protective equipment? For example, safety glasses, gloves, boots, respirator.

   ☐ Always ☐ Most of the time ☐ Sometimes ☐ Never
7. Do you keep your work shoes outside your home and wash your work clothes separately from other laundry?

   ☐ Always ☐ Most of the time ☐ Sometimes ☐ Never
8. In your previous job(s), did you work with or near pesticides? ☐ No ☐ Yes
9. Have you ever been exposed to pesticides by accident? For example, when pesticides were spilled or carried by the wind. ☐ No ☐ Yes
   - Describe what happened.

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California Environmental Protection Agency

SECTION 2. PESTICIDES AT HOME

1. Do you use pesticides at home? For example, weed killer, bait, flea and tick spray or powder, pet collar, etc. ☐ No ☐ Yes

   - Where do you apply them? Check all that apply.

     ☐ Home ☐ Yard & garden ☐ Pets

   – Who applies them? Check all that apply.

     ☐ Yourself ☐ A professional ☐ Another person

   – Where do you store them? Check all that apply.

     ☐ Kitchen ☐ Laundry Room ☐ Garage ☐ Bathroom

     ☐ Other: _____

2. Do you live with anyone who applies or works around pesticides? ☐ No ☐ Yes

3. Do they keep their work shoes outside the home and wash their work clothes separately from other laundry?

   ☐ Always ☐ Most of the time ☐ Sometimes ☐ Never

4. Do you live near an agricultural area? ☐ No ☐ Yes

   – How far away?

     ☐ Less than 1 mile ☐ 1-5 miles ☐ More than 5 miles

   – For how long?

     ☐ Less than 1 year ☐ 1-5 years ☐ More than 5 years

SECTION 3. PESTICIDE ILLNESS

1. Have you ever felt sick while using pesticides or shortly after? ☐ No ☐ Yes

   - Describe your symptoms:

   - Did you go to the doctor for these symptoms?

     ☐ Yes ☐ No ☐ Don't remember

2. Did anyone else around you get sick? ☐ No ☐ Yes