



TOXICITY QUESTIONNAIRE

DATE:	NAME:
SECTION I - POINT SCALE:	
0 = Never have the symptom	
1 = Occasionally have it, effect is not severe	
2 = Occasionally have it, effect is severe	
3 = Frequently have it, effect is not severe	
4 = Frequently have it, effect is severe	

1. HEAD	Headaches	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Faintness	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Dizziness	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Insomnia	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

2. EYES	Watery or itchy eyes	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Swollen, reddened or sticky eyelids	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Bags or dark circles under eyes	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Blurred or tunnel vision (does not include near- or far-sightedness)	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

3. EARS	Itchy ears	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Earaches, ear infections	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Drainage from ear	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Ringling in ears, hearing loss	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

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4. NOSE	Stuffy nose	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Sinus problems	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Hay fever	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Sneezing attacks	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Excessive mucus formation	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

5. MOUTH/THROAT	Chronic coughing	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Gagging, frequent need to clear throat	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Sore throat, hoarseness, loss of voice	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Swollen or discolored tongue, gums, lips	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Canker sores	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

6. SKIN	Acne	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Hives, rashes, dry skin	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Hair loss	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Flushing, hot flashes	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Excessive sweating	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

7. HEART	Irregular or skipped heartbeat	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Rapid or pounding heartbeat	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Chest pain	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

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8. LUNGS	Chest congestion	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Asthma, bronchitis	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Shortness of breath	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Difficulty breathing	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

9. DIGESTIVE TRACT	Nausea, vomiting	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Diarrhea	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Constipation	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Bloated feeling	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Belching, passing gas	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Heartburn	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Intestinal/stomach pain	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

10. JOINTS/MUSCLE	Pain or aches in joint	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Arthritis	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Stiffness or limitation of movement	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Pain or aches in muscles	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Feeling of weakness or tiredness	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

11. WEIGHT	Binge eating/drinking	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Craving certain foods	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Excessive weight	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Compulsive eating	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Water retention	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
Total Page 3:	Underweight	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Date:

Name:

12. ENERGY/ACTIVITY	Fatigue, sluggishness	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Apathy, lethargy	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Hyperactivity	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Restlessness	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

13. MIND	Poor memory	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Confusion, poor comprehension	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Poor concentration	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Poor physical coordination	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Difficulty in making decisions	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Stuttering or stammering	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Slurred speech	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Learning disabilities	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

14. EMOTIONS	Mood swings	0 <input checked="" type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Anxiety, fear, nervousness	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Anger, irritability, aggressiveness	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Depression	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

15. OTHER	Frequent illness	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Frequent or urgent urination	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>
	Genital itch or discharge	0 <input type="radio"/>	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>

Total

SECTION II A to C: Risk of Exposure Date: _____ Name: _____

Rate each of the following situations based upon your environmental profile for the past 12 months.

Section II.A: POINT SCALE: 0=Never, 1=Rarely, 2=Monthly, 3= Weekly, 4=Daily

- _____ 1. How often are chemicals used in your home (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleansers)?
- _____ 2. How often are pesticides used in your home?
- _____ 3. How often do you have your home professionally treated for killing insects?
- _____ 4. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in home/office.
- _____ 5. How often are you exposed to shaving gels, shampoos, hair rinse, nail polish, perfume, hair spray, and other cosmetics?
- _____ 6. How often are you exposed to fumes from diesel, gasoline, exhaust or machinery OR glass, chemicals, metals or any fiber(s) in the air?
- _____ 7. How often do you swim in a pool that uses chlorine?
- _____ 8. How often do you or your dentist use Fluoride on your teeth?
- _____ 9. If you have metals anywhere in your body (head to foot) or amalgam, silver or mercury fillings in your teeth, score 4 for #9.

Section II.B: POINT SCALE: 0=No, 1=Mild Change, 2=Moderate Change, 3= Drastic Change

- _____ 10. Have you noticed any negative change in your health since you moved into your house or apartment when compared to your previous home?
- _____ 11. Have you noticed any negative change in your health since you started your current or new job?

Section II.C: POINT SCALE: 0=No and 2=Yes

- _____ 12. Do you have a Reverse Osmosis Water Purification System in your home?
- _____ 13. Do you have a Shower Filter?
- _____ 14. Do you have a Air Purifier in your home?
- _____ 15. Do you have a Air Purifier in your office or work space?
- _____ 16. Do you have indoor pets at home or work?
- _____ 17. Do you live on or near a farm where pesticides and/or herbicides are used on the land, either applied directly, or by airplane?
- _____ 18. Are you a dentist, artist, painter, ceramist, mortician, mechanic, farm or construction worker, or work in a school, college or carpet store?

PUT SUB-TOTALS OF EACH PAGE IN SPACE BELOW (Sub-Total Is The Total Score For Each Page)

_____ Page 1 Sub-Total
 + _____ Page 2 Sub-Total
 + _____ Page 3 Sub-Total
 + _____ Page 4 Sub-Total
 + _____ Page 5 Sub-Total

FOR EVALUATION OF YOUR TOXICITY QUESTIONNAIRE GRAND TOTAL SCORE
 Go To "Evaluation – Toxicity" webpage at website address below. To open webpage use these PASSCODES: USER'S NAME: toxicity PASSWORD: toxiceval
 Call Dr. Smith at the number below to inquire about how to improve your score, i.e., internally detoxify toxic substance and reduce and/or eliminate risk exposures.

= _____ **GRAND TOTAL** = (Grand Total = the sum of the Sub-Totals of all five pages.)