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	I_I	I_I	I_I	I_I	I_I	___/___/_____	
CHEST TIGHTNESS, DYSPNEA	I_I	I_I	I_I	I_I	I_I	___/___/_____	
AIRWAYS IRRITATION, COUGH	I_I	I_I	I_I	I_I	I_I	___/___/_____	
MUCOSA IRRITATIONS (RHINITIS, STOMATITIS)	I_I	I_I	I_I	I_I	I_I	___/___/_____	
EYE IRRITATION, CONJUNCTIVITIS	I_I	I_I	I_I	I_I	I_I	___/___/_____	
NAUSEA	I_I	I_I	I_I	I_I	I_I	___/___/_____	
DIZZINESS	I_I	I_I	I_I	I_I	I_I	___/___/_____	
MUSCLE CRAMPS	I_I	I_I	I_I	I_I	I_I	___/___/_____	
CONCENTRATION DISORDERS	I_I	I_I	I_I	I_I	I_I	___/___/_____	
DYSGEUSIA	I_I	I_I	I_I	I_I	I_I	___/___/_____	
NUMBNESS	I_I	I_I	I_I	I_I	I_I	___/___/_____	
DIARRHEA, ABDOMINAL CRAMPS	I_I	I_I	I_I	I_I	I_I	___/___/_____	
WEAKNESS, FATIGUE	I_I	I_I	I_I	I_I	I_I	___/___/_____	
SEIZURES	I_I	I_I	I_I	I_I	I_I	___/___/_____	
DISTURBANCE OF						___/___/_____	

DISTURBANCE OF MEMORY	I_I	I_I	I_I	I_I	I_I	___/___/_____	
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	I_I	I_I	I_I	I_I	I_I	___/___/_____	
SADNESS, DEPRESSION	I_I	I_I	I_I	I_I	I_I	___/___/_____	
SLEEP DISORDER	I_I	I_I	I_I	I_I	I_I	___/___/_____	
IMPAIRED BALANCE, DISTURBED GAIT	I_I	I_I	I_I	I_I	I_I	___/___/_____	
TREMOR	I_I	I_I	I_I	I_I	I_I	___/___/_____	
OTHER, PLEASE SPECIFY _____	I_I	I_I	I_I	I_I	I_I	___/___/_____	

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:
    - I_I ARTHRITIS, SPECIFY _____
    - I_I RHEUMATIC DISEASE, SPECIFY _____
    - I_I ASTHMA, SPECIFY _____
    - I_I CHRONIC BRONCHITIS _____
    - I_I CANCER, SPECIFY _____
    - I_I DIABETES, SPECIFY _____
    - I_I KIDNEY DISEASE, SPECIFY _____
    - I_I LIVER DISEASE, SPECIFY _____
    - I_I CENTRAL/PERIPHERAL NERVOUS SYSTEM DISEASE, SPECIFY _____
    - I_I 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 CONSUMTION

WINE_____ **BEER**_____ **HIGH% SPIRITS** _____

HOW MANY TIMES PER WEEK?_____

17. **ADDITIONAL INFORMATION IF NEEDED:** _____

_____

_____

THANK YOU VERY MUCH FOR YOUR COOPERATION!

see also :

http://www.eomsociety.org/attachments/FUM-EX%202_%20QUESTIONNAIRE_EOM%20FRENCH%20VERSION.pdf

for the French Version of the Questionnair