

Original Date:	
Dates Revised:	

LEAD EXPOSURE QUESTIONNAIRE

Name: _____ ☐ M ☐ F SSN: _____

Age: _____ Date: _____

Please answer the following by checking the appropriate response:

<u>OCCUPATIONAL HISTORY</u>		
1. Have you engaged in any hobbies involving exposure to lead?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Do you currently work with lead or lead containing compounds?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Have you worked with lead or lead containing materials in the past?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Have you been required in any job to wear personal protection for lead	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Have you ever had your blood checked for lead?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If you answered 'YES' to any of the above questions please give details:

MEDICAL HISTORY

6. Do you have a history of anemia, kidney disease, liver disease or disease of the nervous system or a learning difficulty?

If 'YES' please explain:

Please continue to next page

7. Please check any of the following symptoms you have experienced in the past six months:

<input type="checkbox"/> abdominal pain	<input type="checkbox"/> abnormal taste	<input type="checkbox"/> constipation
<input type="checkbox"/> loss of appetite	<input type="checkbox"/> fatigue	<input type="checkbox"/> numbness of extremities
<input type="checkbox"/> confusion	<input type="checkbox"/> dizziness/coordination difficulties	<input type="checkbox"/> other nervous problems

If 'YES" please explain:
