NEOMA 2009

Jonathan S. Rutchik, MD, MPH

Neurology and Electromyography, Occupational and Environmental Medicine

Diplomat of the American Board of Psychiatry and Neurology (Neurology)

Diplomat of the American Board of Preventive Medicine (Occupational and Environmental Medicine)

http://www.NEOMA.com

20 Sunnyside Avenue, Suite A-321
Mill Valley, Ca 94941
Email:jsrutch@neoma.com

PHONE: 415-381-3133
FAX: 415-381-3131
CELL: 415-606-1465

CALIFORNIA STATE QUALIFIED MEDICAL EXAMINER

San Francisco, Richmond, Petaluma, Sacramento and Eureka area, California

OCCUPATIONAL AND ENVIRONMENTAL NEUROLOGY QUESTIONNAIRE

1 NAME_____

2. ADDRESS_____
_____
_____

3. PHONE_____

4. PERSON FILLING OUT THIS FORM (IF OTHER THAN PATIENT)_____

5. WHO REFERRED YOU TO DR. RUTCHIK?_____

6. WHERE CONSULTATION REPORT SHOULD BE SENT (ADDRESS)_____
_____

INFORMATION/ PERSONAL DATA

7. WHAT IS THE REASON YOU HAVE BEEN REFERRED HERE? CIRCLE ONE:

WORK RELATED INJURY ENVIRONMENTAL INJURY

8. LIST MEDICAL PROBLEM IN **ONE LINE SENTENCE**
_____
_____
_____
_____

9. TODAY'S DATE_____ 10. SOCIAL SECURITY NUMBER_____

11. DATE OF BIRTH_____ 12. AGE_____ 13. SEX: CIRCLE: M / F

14. HEIGHT_____ 15. WEIGHT_____ 16. RACE_____17. RELIGION_____

18. PRESENT MARITAL STATUS_____ 19. EDUCATION- HIGHEST GRADE COMPLETED_____

20. AVERAGE GRADE IN SCHOOL_____ 21. YEARS FATHER COMPLETED IN SCHOOL_____

22. FATHER'S OCCUPATION_____ 23. YEARS MOTHER COMPLETED IN SCHOOL_____

24. MOTHER'S OCCUPATION_____

CHEMICAL EXPOSURES

25. PLEASE **CIRCLE** CHEMICALS TO WHICH YOU HAVE BEEN EXPOSED. SPECIFY WHETHER YOU WERE EXPOSED AT WORK OR IN ANOTHER SETTING, WHEN YOU WERE EXPOSED AND HOW THE CHEMICAL WAS USED WHEN YOU WERE EXPOSED.

SUBSTANCE	WHEN	WHERE AND CIRCUMSTANCE
ARSENIC		
LEAD		
MANGANESE		
MERCURY		
TIN		
ACRYLAMIDE		
CARBON DISULFIDE		
ETHYLENE OXIDE		
METHYL TERTIARY BUTYL KETONE		
METHYLENE CHLORIDE		
N HEXANE		
PERCHLORO-ETHYLENE		
TOLUENE		
TRICHLORO-ETHYLENE		
PESTICIDES		
CARBON MONOXIDE		
GASOLINE		
OTHER SOLVENTS:		

OCCUPATION

26. ARE YOU CURRENTLY WORKING? CIRCLE: YES NO

27. MONTH AND YEAR CURRENT OR LAST JOB BEGAN_____

28. MONTH AND YEAR CURRENT OR LAST JOB ENDED _____

29. IF NOT CURRENTLY WORKING: WHAT IS THE REASON? CIRCLE ONE BELOW

FIRED QUIT RETIRED MEDICAL DISABILITY OTHER

_____

30. ARE YOU PRESENTLY COLLECTING MEDICAL DISABILITY OR SOCIAL SECURITY COMPENSATION? YES NO

EXPLAIN IF YES, INCLUDED DATE BEGAN_____

31. WHAT IS YOUR PRESENT OR LAST OCCUPATION?

_____

_____

32. PLACE OF EMPLOYMENT (INCLUDE ADDRESS)

_____

_____

33. DESCRIBE MOST RECENT JOB (INCLUDE HOURS PER DAY, PER WEEK AND SPECIFIC JOB TASKS)

34. DESCRIBE SPECIFICALLY ANY CHEMICAL SUBSTANCE AND/ OR PHYSICAL AGENT EXPOSURES AT JOB SITE (INCLUDE HOURS PER DAY AND WEEK AND CIRCUMSTANCES SUROUNDING THESE)

EMPLOYMENT

35. PLEASE LIST ALL JOBS FROM PAST TO PRESENT

JOB: TITLE AND DUTIES	PLACE OF WORK, NAME OF COMPANY AND LOCATION	DATES OF EMPLOYMENT	EXPOSURES	HEALTH PROBLEMS ASSOCIATED WITH WORK?	HOME ADDRESS DURING THIS JOB

WORKER HEALTH

36. HAVE YOU HAD ANY MEDICAL PROBLEMS POSSIBLY RELATED TO WORK? CIRCLE YES NO
IF YES, PLEASE DESCRIBE.

37. HAVE ANY OF YOUR FELLOW WORKERS HAD A MEDICAL PROBLEM POSSIBLY RELATED TO WORK? IF YES, PLEASE DESCRIBE.

38. WHAT ARE YOUR WORK HABITS? DO YOU USE... (CIRCLE)

EAR PLUGS OR MUFFS GOGGLES OR FACE MASK DUST MASK RESPIRATOR

GLOVES APRON OR GOWN STEEL TOES SHOES OTHER

39. HOW OFTEN? CIRCLE: NEVER 25% 50% 75% 100%

40. WHAT IS THE REASON FOR WEARING THESE?
_____
_____

41 ARE THESE PROVIDED FOR YOU? CIRCLE YES NO

42. HAVE YOU EVER RECEIVED INSTRUCTIONS REGARDING PROPER USAGE AND CARE OF A RESPIRATOR? CIRCLE YES NO

43. DO YOU. . . CIRCLE IF YES
>WASH HANDS BEFORE EATING AT WORK?

>SHOWER AND/ OR CHANGE CLOTHES BEFORE GOING HOME FROM WORK?

>SMOKE AT WORK?

44. IS THERE A LUNCH ROOM AT WORK OR DO YOU EAT AT THE SAME LOCATION WHERE YOU WORK?

45. DOES YOUR SPOUSE OR OTHER HOUSEHOLD MEMBER WORK? CIRCLE: YES NO

46. WHAT IS/ ARE THEIR OCCUPATION? 47. PLACE OF EMPLOYMENT?

48. IS HE / SHE EXPOSED TO ANY CHEMICALS AT THIER WORK SITE? CIRCLE: YES NO
IF YES, PLEASE DESCRIBE.

MEDICAL HISTORY

49. HAVE YOU EVER BEEN HOSPITALIZED? IF YES, PLEASE DESCRIBE AND GIVE DATES AND LOCATIONS.

50. HAVE YOU EVER HAD SURGERY? IF YES, PLEASE DESCRIBE AND GIVE DATES AND LOCATIONS.

51. DO YOU HAVE ANY ALLERGIES? PLEASE LIST. AND DESCRIBE THE REACTION NOTED.

52. HAVE YOU EVER HAD A HEAD INJURY?
IF YES, DID YOU LOSE CONSCIOUSNESS FROM IT? PLEASE NOTE DATE(S).

53. WHAT ARE THE MEDICATIONS THAT YOU TAKE NOW? (LIST WITH REASON OR MEDICAL CONDITION FOR WHICH YOU ARE TAKING THESE, DOSES AND NOTE DATE STARTED AND FINISHED FOR EACH)

54. PLEASE LIST ALL OTHER MEDICATIONS YOU HAVE TAKEN. (INCLUDE DATES AND REASONS FOR TAKING AND DOSES)

55. LIST ANY OTHER INJURIES OR ACCIDENTS THAT YOU HAVE HAD. PLEASE LIST DATES AND EXPLAIN ALL RESPONSES. WHAT ARE LIMITATIONS OF THIS CONDITION TODAY?

MEDICAL HISTORY

56. **CIRCLE** THE MEDICAL CONDITIONS THAT **YOU HAVE BEEN DIAGNOSED WITH**.

>MARK AN *"X"* NEXT TO THE MEDICAL PROBLEMS THAT SOMEONE IN ***YOUR IMMEDIATE FAMILY HAS BEEN DIAGNOSED WITH.***

DIABETES
HEART DISEASE
THYROID DISEASE
LIVER DISEASE
BRONCHITIS
ARTHRITIS
GOUT
BACK PAINS
DEPRESSION
ALCOHOLISM
EATING DISORDER
FIBROMYALGIA
SEIZURES
NEUROPATHY
STROKE
MULTIPLE SCLEROSIS
CEREBRAL PALSY
MUSCULAR DYSTROPHY
HUNTINGTON'S DISEASE
OTHER: LIST BELOW

HIGH BLOOD PRESSURE
HEART DISEASE
KIDNEY DISEASE
ASTHMA
STOMACH PROBLEMS
ANEMIA
VITAMIN DEFICIENCY
NECK PAINS
PSYCHIATRIC ILLNESS
CHRONIC FATIGUE SYNDROME
SLEEP DISORDER
HEADACHES
CARPEL TUNNEL SYNDROME
CANCER
SENILITY/ DEMENTIA/ ALZHEIMER'S DISEASE
PARKINSON'S DISEASE
LEARNING DISORDER
TREMORS

57. **EXPLAIN THE POSITIVE RESPONSES ON THE OTHER SIDE OF THIS PAGE:**
INCLUDE DATE OF DIAGNOSIS, WHETHER YOU ARE TAKING MEDICINE FOR THE CONDITION, WHETHER THE DISEASE AFFECTS YOU NOW.

SYMPTOMS

58. **CIRCLE SYMPTOMS THAT YOU ARE EXPERIENCING**

MOOD CHANGES
DIFFICULTY CONCENTRATING
CONFUSION
TROUBLE WITH MEMORY
CHANGE IN PERSONALITY
ANXIETY
DEPRESSION
FATIGUE
TROUBLE SLEEPING
HEADACHES
DIZZINESS OR VERTIGO
VISUAL CHANGES
HEARING CHANGES
DIFFICULTY CHEWING
FACIAL NUMBNESS
CHANGE IN ABILITY TO TASTE
CHANGE IN ABILITY TO SMELL
CHANGE IN VOICE
FAINTING SPELLS
HEAT INTOLERANCE
DIFFICULTY WITH SUNLIGHT
LOSS OF BALANCE
DIFFICULTY WITH ERECTIONS (MALE) OR SEXUAL FUNCTION (M OR F)
OTHER SYMPTOMS: LIST BELOW:

ABDOMINAL PAIN
NAUSEA AND VOMITING
DIARRHEA
CONSTIPATION
SKIN RASHES
UNINTENTIONAL WEIGHT LOSS OR GAIN
JOINT PAINS
SHORTNESS OF BREATH
CHEST PAINS
LOSS OF APPETITE

CHANGE IN WALKING
TREMORS OR SHAKINESS
CHANGES IN HANDWRITING
CHANGES IN FACIAL EXPRESSION
DIFFICULTY TURNING IN BED
NUMBNESS AND TINGLING IN HANDS
NUMBNESS AND TINGLING IN FEET
MUSCLE WEAKNESS IN LEGS AND FEET
MUSCLE TWITCHING OR JERKING
COLD FINGERS
LOSS OF SEXUAL INTEREST

59. **EXPLAIN POSITIVE RESPONSES BELOW OR ON OTHER SIDE OF THIS PAGE**. **DESCRIBE SYMPTOMS CLEARLY; WHEN AND WHERE DO THEY OCCUR?; WHAT TIME OF THE DAY?; WHAT BRINGS THE SYMPTOMS ON? WHEN DID YOU FIRST NOTICED THEM?; HAVE THEY IMPROVED OR WORSENED SINCE YOU FIRST NOTICED THEM? HOW ARE THEY NOW?**

OTHER EXPOSURES

60. DO YOU DRINK ALCOHOL NOW? CIRCLE YES NO
IF YES, SPECIFICALLY HOW OFTEN PER DAY AND WEEK AND FOR HOW LONG AT THIS AMOUNT?

61. DID YOU EVER DRINK? CIRCLE YES NO
IF YES, SPECIFICALLY HOW OFTEN PER DAY AND WEEK AND FOR HOW LONG AT THIS AMOUNT?

62. HAVE YOU EVER CHANGED YOUR DRINKING PATTERN? CIRCLE YES NO
IF YES, WHEN AND FROM HOW MUCH TO HOW MUCH?

63. DO YOU EVER DRINK ALCOHOL ON THE JOB? CIRCLE YES NO
IF YES, HOW OFTEN PER DAY AND WEEK?

64. DO YOU SMOKE NOW? CIRCLE YES NO HOW? CIRCLE CIGARETTE PIPE CIGAR
IF YES, SPECIFICALLY HOW OFTEN PER DAY AND WEEK? AND FOR HOW LONG AT THIS AMOUNT?

65. DID YOU EVER SMOKE? CIRCLE YES NO
IF YES, SPECIFICALLY HOW OFTEN PER DAY AND WEEK AND FOR HOW LONG AT THIS AMOUNT?

66. HAVE YOU EVER CHANGED YOUR SMOKING PATTERN? CIRCLE YES NO
IF YES, WHEN AND FROM HOW MUCH TO HOW MUCH?

67. DO YOU EVER SMOKE ON THE JOB? CIRCLE YES NO
IF YES, HOW OFTEN?

68. DO YOU DRINK CAFFEINATED BEVERAGES? CIRCLE YES NO.
EXAMPLES ARE COFFEE, TEA, AND SODAS. HOW MUCH AND HOW OFTEN PER DAY AND WEEK?

69. HOW OFTEN DO YOU EAT THESE FOODS PER WEEK?
FISH AND WHITE MEATS (TURKEY AND CHICKEN)
RED MEAT?
EGGS?
FRESH VEGETABLES?
MILK PRODUCTS?

70.

ENVIRONMENTAL EXPOSURES

PRESENT AND PAST ADDRESSES	MONTH AND YEAR FIRST AND LAST @LOCATION	WELL WATER SOURCE OF DRINKING? SHOWERING? YEARS?	LANDMARKS NEARBY

USE OTHER SIDE IF NECESSARY.

72. FOR THE RESIDENCE IN QUESTION, HOW MANY BATHS AND SHOWERS DO YOU TAKE PER DAY? PER WEEK?

73. FOR THE RESIDENCE IN QUESTION, HOW MUCH GLASSES OF TAP WATER DO YO DRINK PER DAY?

74. DOES THE RESIDENCE IN QUESTION HAVE A SWIMMING POOL? HOW MANY TIMES PER WEEK DO YOU SWIM?

75. DOES THE RESIDENCE IN QUESTION HAVE A DISH WASHING MACHINE?

76. FOR THE RESIDENCE IN QUESTION, WHAT ARE THE NATURAL OR MAN MADE LANDMARKS NEARBY?

LANDMARK	DISTANCE FROM HOME
RIVER, LAKE OR STREAM	
MOUNTAIN	
RAILROAD TRACKS	
ELECTRICAL POWER LINES	
WASTE SITE, LANDFILL OR DUMP	
SEWAGE TREATMENT PLANT	
NUCLEAR POWER PLANT	
OTHER	

77. DO YOU HAVE ANY HOBBIES THAT REQUIRE GLUES, PAINTS, GARDENING MATERIALS OR OTHER CHEMICALS? LIST THEM PLEASE.

78. WHERE DO YOU DO THESE ACTIVITIES?

79. DO YOU USE ANY RECREATIONAL DRUGS? EXAMPLES: MARIJUANA, COCAINE, AMPHETAMINES, GLUE SNIFFING, WHIP-ITS, HALLUCINOGENS? IF, YES HOW OFTEN?

REPRODUCTIVE HISTORY

80. IF YOU ARE FEMALE... ARE YOUR PERIODS NORMAL? CIRCLE Y / N
IF NO, PLEASE DESCRIBE. SINCE WHEN HAS THIS PROBLEM OCCURRED?

81. HAVE YOU TAKEN ORAL CONTRACEPTION? CIRCLE YES NO.
SINCE WHEN AND UNTIL WHEN?

82. HAVE YOU EVER BEEN PREGNANT? CIRCLE YES NO.
IF YES, HOW MANY PREGNANCIES AND HOW MANY CHILDREN?

83. HAVE YOU EVER HAD TROUBLE GETTING PREGNANT? CIRCLE YES NO.
IF YES PLEASE DESCRIBE.

84. HAVE YOU EVER HAD A MISCARRIAGE OR HAD A CHILD WITH A BIRTH DEFECT?
CIRCLE YES NO. IF YES WHEN. PLEASE DESCRIBE.

85. IF YOU ARE MALE. HAS YOUR WIFE EVER HAD …
CIRCLE A MISCARRIAGE, A CHILD BORN WITH A BIRTH DEFECT OR DIFFICULTY BECOMING PREGNANT? IF YES, PLEASE DESCRIBE?

86. DO YOU HAVE ANY CHILDREN? IF YES, HOW MANY?

87. IF YOU ARE A MALE. DO YOU HAVE PROBLEMS WITH YOUR SEXUAL PERFORMANCE?
SINCE WHEN? IS YOUR PROBLEM WITH ERECTIONS OR MOOD OR BOTH? PLEASE EXPLAIN.

EXERCISE AND ACTIVITIES QUESTIONS

88. **WHAT ARE YOUR DAILY ACTIVITIES FROM WAKING TO BEDTIME? BE DETAILED AND SPECIFIC.**

89. **HOW MUCH AND WHAT TYPES OF EXERCISE DO YOU DO? BE SPECIFIC**

90. HOW MUCH DO YOU SLEEP AT NIGHT? HOW MANY HOURS AND HOW MANY DAYS DO YOU WAKE RESTED?

THANK YOU. JSR