THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Toxin Exposure Questionnaire

Patient Name _____ *Date* _____

Please mark your response for each of the following questions. Your provider will discuss your answers with you.

Food and Water

1. Do you eat conventionally-farmed (non-organic) or genetically-modified fruits and vegetables?
   ☐ Yes ☐ Sometimes ☐ In the Past ☐ No
2. Do you eat conventionally-raised (non-organic) animal products (e.g., meat, poultry, dairy, eggs)?
   ☐ Yes ☐ Sometimes ☐ In the Past ☐ No
3. Do you eat canned or farmed fish and seafood?
   ☐ Yes ☐ Sometimes ☐ In the Past ☐ No
4. Do you eat processed foods (e.g., foods with added artificial colors, flavors, preservatives), deep-fried foods, or fast foods?
   ☐ Yes ☐ Sometimes ☐ In the Past ☐ No
5. Do you drink water from a well, spring, or cistern, or from plumbing pipes or fixtures installed before 1986?
   ☐ Yes ☐ Sometimes ☐ In the Past ☐ No
6. Do you drink sodas, juices, or other beverages with natural or refined sweeteners (high-fructose corn syrup, cane sugar, agave nectar, stevia, undiluted fruit juice, etc.) or artificial sweeteners (i.e., Equal® or aspartame; Sweet'N Low®, Sugar Twin®, or saccharin; Splenda® or sucralose; Sunett®, Sweet One®, or acesulfame-K; and neotame)?
   ☐ Yes ☐ Sometimes ☐ In the Past ☐ No

Home and Work Environment

1. Do you live in an apartment or home built before 1978 or in a mobile home, boat, or recreational vehicle (RV)?
   ☐ Yes ☐ Sometimes ☐ In the Past ☐ No
2. Does your home or workplace contain new furniture, bedding, or construction materials (paint, laminate flooring, etc.)?
   ☐ Yes ☐ Sometimes ☐ In the Past ☐ No
3. Does your home or workplace show signs of mold or water damage (e.g., cracking paint, ceiling leaks, decaying insulation or foam, visible mold, or damp areas in windows, crawlspaces, or the basement)?
   ☐ Yes ☐ Sometimes ☐ In the Past ☐ No
4. Are you exposed to toxic substances (e.g., treated lumber; lead paint, paint chips, or dust; broken mercury thermometers or fluorescent bulbs) at home or work?
   ☐ Yes ☐ Sometimes ☐ In the Past ☐ No
5. Are you exposed to conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or work?
   ☐ Yes ☐ Sometimes ☐ In the Past ☐ No
6. Do you live or work near an industrial pollution source (e.g., highway, factory, incinerator, gas station, power plant)?
   ☐ Yes ☐ Sometimes ☐ In the Past ☐ No

Home and Work Environment *(continued)*

7. Do you live or work near a source of electromagnetic radiation (cell phone tower, high-voltage power lines, etc.)?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

8. Do you live or work in an agricultural area or other area where you are exposed to herbicides, pesticides, or fungicides?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

9. Do you have woodburning, propane, or gas stoves or appliances at home or work?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

10. Do you live or work in a sealed building with recirculated air?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

Travel and Recreation

1. Do you go to parks, golf courses, or other outdoor or recreational areas treated with herbicides, pesticides, or fungicides?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

2. Do you travel by air?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

3. Do you run or bike to work along busy streets?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

4. Do you get sick while camping, hiking, or traveling (foreign or domestic)?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

5. Are you exposed to toxic chemicals as a result of a hobby (paints, photo-developing chemicals, epoxy adhesives, glues, varnishes, etc.)?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

Medical and Personal Care

1. Are you sensitive to personal care products like lotions, moisturizers, shampoos, conditioners, shaving creams, and soaps?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

2. Are you sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

3. Do you smoke, or are you often exposed to secondhand smoke?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

4. Do you have a history of heavy use of alcohol or recreational or prescription drugs?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

5. Do you have any unusual reactions to anesthesia or to prescription or over-the-counter medications?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

6. Do you have root canals, extracted teeth, dental implants, "silver" fillings, crowns, dental sealants, dentures, retainers, aligning trays, braces, or mouth guards?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

7. Do you have food reactions, sensitivities, or intolerances?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

8. Do you have environmental allergies?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

9. Do you have any artificial materials in your body (implants, pins, joints, etc.)?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

10. Do you lead a high-stress lifestyle, or have you experienced a stressful or traumatic event?
☐ Yes ☐ Sometimes ☐ In the Past ☐ No

Note: For more information on the questions included here, please see IFM's **Toxin Exposure Questionnaire—Bibliography**.