Chapter 4
Medications and Biological Management

DRUGS & BIOLOGICAL POLICY

PURPOSE: Secure storage of drugs and biological materials.

POLICY:

1. All medications and biological materials, including samples, will be stored safely in one of the following

places:

- Locked cabinet.
- Locked medication room.
- Locked medication refrigerator.

2. No narcotics will be stored at the clinic.

MEDICATION RECALLS

Refer to Clinton Regional Hospital policy and procedure on the shared drive.

Access instructions: shared drive, Public, Policy and Procedures, Pharmacy, Drugs_Recalls

Clinton Regional Hospital Pharmacy Director Cris Hickerson, DPh

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PHARMACEUTICAL REPRESENTATIVES

POLICY: It is the policy of the Clinic that visits from pharmaceutical representatives will be scheduled. PROCEDURES:

1. A calendar of available dates for lunches with pharmaceutical representatives should be maintained by the Office Coordinator.

2. All communications from pharmaceutical representatives should be coordinated with the clinic nurse and/or provider. The Office Coordinator will contact the representatives to confirm a date for lunches or other meetings.

3. The pharmaceutical representatives will not stock their own sample medications or check current medications for expiration, and they should NEVER have access to the drug storage area

4. Pharmaceutical representatives will leave literature directly with the Providers and/or clinical team. They should never be allowed to distribute literature to patients.

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DRUG SAMPLES

Providers may dispense sample medications to their patients when available, and when done in accordance with the following procedures:

RECEIPT: The pharmaceutical representative may leave samples for patient distribution. These samples are signed out to the Provider by the pharmaceutical representative, and, in multi-Provider Clinics, should be signed out to individual Providers.

STORAGE:

1. All samples should be stored in a secure region of the Clinic that is not located in a patient care area.

2. Access to sample areas should be locked at all times.

DISPENSING:

1. Medications may only be dispensed in one of two ways:

a. Upon the Provider's order by a licensed nurse.

b. Directly by the Provider.

2. Each Provider may dispense from the Clinic stock of sample pharmaceuticals, so long as the sample is logged out appropriately on the "Sample Medication Log".

3. Instructions to the patient should be documented, with the original provided to the patient/representative and a copy filed in his/her medical record.

4. Sample pharmaceuticals are recorded on the "Sample Medication Log" before distribution. Documentation on the Sample Medication Log include:

- Patient Name
- Name and Strength of Medication.
- Lot Number and Expiration Date.
- Date of Distribution.
- Applicable to multiple provider office with samples: Name of provider dispensing

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DRUG SAMPLES CONTINUED

1. Documentation in the medical record includes:

a. Medication and Strength.

b. Lot Number and Expiration Date.

c. Quantity dispensed.

d. Instructions to Patient. Inventory Control:

1. Sample pharmaceutical inventory control log sheets should be kept in a three-ring binder when each sheet is completely full.

2. Samples should be checked monthly, to assure all products are at least one month prior to expiration. Stock should be rotated as new samples of product are received.

3. On a monthly basis, inventories should be checked to be sure that the number received minus the number displayed is equal to the number left in stock. This should be done a few drugs at a time so that all drugs in inventory are checked on a quarterly basis.

4. No narcotics will be kept in the Clinic.

5. Outdated/expired pharmaceuticals, samples, test strips, or clinic injectables are removed and taken to

Clinton Regional Hospital Pharmacy or placed in designated receptacle for destruction. DO NOT DISCARD MEDICATIONS IN REGULAR TRASH CONTAINERS. The nurse will note date of removal in log sheet, maintaining records on all discarded items.

NOTE: Any variance from this policy must be approved by the Medical Practice Manager.

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PATIENT FOOD AND DRINK

Clinton Regional Hospital Clinics does not maintain patient food or drink.

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TRANSMISSION OF PRESCRIPTIONS

PURPOSE: To provide guidelines consistent with the Department of Professional Regulations in the transmission of prescriptions.

Mid-Level Provider Protocols

In order to reduce the risk of errors when transmitting prescriptions, the following protocols will be utilized by the Mid-level Provider.

1. The Supervising Physician delegates prescriptive authority through the Department of Professional Regulation for legend drugs and controlled substances.

2. The Mid-level Provider may prescribe all medications that are appropriate and consistent with the treatment of various conditions and are within the scope of practice of his/her Supervising Physician in accordance with state guidelines.

3. At his/her discretion, the Supervising Physician may establish a list of medications that the Mid-level Provider is not approved to prescribe.

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SAFETY MEASURES FOR DRUG ADMINISTRATION

1.0PURPOSE

1. To provide guidelines for administration of medications.

2. .0POLICY

1. A physician's order is required for the administration of any medication.

1. A CRNA may also write medication orders if they have prescriptive authority.

2. The patient's current allergies, height, and weight should be available prior to administering any medication.

3. All medication order transcription will be noted by a licensed nurse.

4. Qualified persons who have passed competency exams may administer medications within this institution. Care will be taken to ensure that patient's medications are given after allergies are obtained and verified and:

- to the right patient
- at the right time
- by the right route
- in the right dosage
- the right medication

1. In addition the nurse will ensure that:

- The order is correct
- Correct documentation is completed
- Medication education is provided

2.5 Students of nursing programs affiliated with this hospital may prepare and administer medication under the supervision of an RN instructor or RN preceptor. Nursing students employed as Nurse Technicians or as Nurse Externs may not administer medications while working in that capacity.

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3.0 PROCEDURE

1. Responsible Party: Health Unit Coordinator (HUC), RN/LPN, RPh.

1. Receives a written order:

1. The pharmacist and nurse are notified immediately for stat and now orders.
2. The patient's height, weight, current allergy status, medication reconciliation record, and any new order(s) will be provided to pharmacy upon admission.
3. Allergies will be clearly marked on the front of the patient's medical record, admission assessment, medication reconciliation form, medication administration record (MAR), and the pateint's allergy identification bracelet.
4. All orders will be copied and sent to pharmacy upon receipt of the order.

• Medications will be available from the Omnicell after pharmacy has reviewed the orders and entered the orders into the system.

2. Responsible Party: RN/LPN

1. For procedural information regarding medication administration techniques, please refer to Mosby's Nursing Skills available on the inside page.
2. Insulin, heparin, IV digoxin, and antineoplastic drugs will be verified with another licensed nurse, pharmacist, or LIP prior to administration. The verification process includes:

1. Physician's order
2. Allergies
3. Right patient
4. Right medication
5. Right dose
6. Right route
7. Right time

3. Procurement of Medications:

1. Pharmacy hours are 0700 - 1600. A pharmacist is on call during nonpharmacy hours.
2. All medication new orders are to be transcribed onto the Medication Administration Record. (MAR). All orders will be checked by licensed personnel for accuracy and noted on the physician's orders.
1. The date, and time the order is noted will precede the signature and title of the licensed nurse.
2. Medications obtained from the Pyxis after hours must be verified by 2 licensed nurses in order to override the system.
3. Medication whose dosage is different from the available form requires a witness to verify the dose on the Pyxis.

3.3 Administering medications:

1. "STAT" orders are to be administered immediately or at once; within 15 minutes of receiving the order.
2. "Now" orders are to be administered within 45 minutes of receiving the order.
3. Multiple dose vials are wasted within 30 days of being initially opened. The vial is labeled with colored label indicating the original date opened. Single use vials are not to be used for more than one dose.
4. STAT, Now, or one-time medications are recorded on the MAR. After these medications are administered, the nurses' initials and time are documented and the line "yellowed out".

4. Medication errors/discrepancies will be reported to the clinical director, lead nurse, or house supervisor. A medication variance report will be completed. The physician, patient and pharmacy will also be notified.
5. Adverse medication reactions:

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1. In the event of an adverse medication reaction the clinical director, lead nurse, house supervisor, pharmacist, and the physician will be notified. The patient is observed for the severity of the reaction, appropriate assessment data, interventions, and response documented in the nursing narrative. An "Adverse Reaction Report" is to be completed and sent to pharmacy for review.

6. 24 Hour Order Verification: Responsible Party: RN-LPN11/7

1. A licensed nurse will review and verify all orders to ensure accuracy comparing the physician's orders with the MAR for the previous 24 hour period.

1. The last order reviewed should be identified with a star or astric or by writing "24 hour chart check" and the and the reviewing nurse's initials.

2. The licensed nurse will make necessary changes on the MAR to maintain accuracy.

7. Patient transfer to a different unit

1. The medication reconciliation form will be printed and the physician will review the hospital medication reconciliation form with the admission reconciliation form and the meds will be checked indicating whether they are to be continued or discontinued. The med reconciliation form serves as a physician's order and a copy will be sent to pharmacy.

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SCHEDULED DRUG PRESCRIPTION MONITORING

In order to provide quality care and to prevent inappropriate utilization of scheduled medications, the following procedures will be followed:

1 Mid-level Providers, according to Oklahoma state laws, will prescribe or dispense only scheduled medications in classes III through V.

2 Schedules III, IV, and V:

a. These prescriptions may be oral or written.

b. Refills of prescriptions will be at the discretion of the Providers.

3 The Supervising Physician will monitor the utilization of scheduled medications by periodic review of the charts of the Mid-level Provider. Any use of a scheduled medication falling outside the limits set by this policy will be brought to the attention of the Mid-level Provider and a note of the same will be placed in the Mid-level's record review file.

4 If a pattern of inappropriate use develops, the Mid-level Provider will be disciplined as determined by the Clinic Director and the Supervising Physician.

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EMERGENCY RESPONSE KIT POLICY

PURPOSE: To ensure an emergency response kit is maintained in the clinic.

POLICY: The clinic shall maintain an emergency response kit contained in an easily-accessed container, will all supplies on the list contained in the container. This kit shall be maintained in designated area of the clinic.

EMERGENCY KIT

This clinic provides medical emergency procedures as a first response to common life threatening injuries, acute illness and have available the drugs and biologicals commonly used in life saving procedure. To include:

Category	Description	Clinton Regional Hospital Clinic Sample
Analgesics	Insensibility to pain without loss of consciousness	Chewable Aspirin 81mg Ketorolac 60mg
Anesthetics, (Local)	Loss of sensation especially to touch usually resulting from a lesion in the nervous system or from other abnormality	Lidocaine 1% w/Epi Lidocaine 1% Without Epi
Antibiotics	A substance produced by or a semisynthetic substance derived from a microorganism and able to dilute solution to inhibit or kill another microorganism	Rocephin 1g
Anticonvulsants	An abnormal violent and involuntary contraction or series of contractions of the muscles—often used in	Keppra 500mg

	plural < a patient suffering from convulsions>	
Antidotes	A remedy that counteracts the effects of poison	Epinephrine, Naloxone, Diphenhydramine 50mg
Emetics	An agent that induces vomiting	Activated Charcoal
Serums	The watery portion of an animal fluid remaining after coagulation: a (1): the clear yellowish fluid that remains from blood plasma after fibrinogen prothrombin, and other clotting factors have been removed by clot formation—call also blood serum	Influenza
Toxoids	A toxin of a pathogenic organism treated so as to destroy its toxicity but leaves it capable of inducing the formation of antibodies on injection>-- called also anatoxin	Tetanus/Diphtheria

Must have Emergency Response Kit on-site, however, not a recommended procedure in a clinic. Usually reserved for emergency room only.

• All above drugs should be securely located in a kit, marked "Emergency Response Kit," a copy of contents to be located inside the kit and a copy outside of the "locked" or "tagged" kit with expiration dates. This kit should have a log "Emergency Response Kit" log showing the kit has been checked on a daily basis for expired medications and to ensure the kit lock/tag is intact. Once the kit has been opened, pharmacy will be notified to

replace the emergency kit.

These items shall be kept in a central location and shall be in sufficient supply necessary to treat those emergencies. It is mandatory that all employees are familiar with the location of the emergency supplies and able to recognize the name of same. It is also strongly encouraged that the staff maintains current CPR certification.

The Medical Director develops a protocol for the staff for specific emergency situation and reviews the protocols at least annually and has a surprise drill at least annually.

EMERGENCY OXYGEN

Emergency oxygen is located at designated area that is marked by appropriate signage. Oxygen tank is stored in secure holder in an upright position with adult and pediatric oxygen delivery device attached to the tank. The tank is checked daily to ensure that the tank is filled to the appropriate level. Daily check of the tank is logged on the Daily Emergency Oxygen Log. For oxygen bottles designated as emergency, the tank must be at least 50% full. When the tank reaches 50% it is the job of the nurse to contact Clinton Regional Hospital Cardiopulmonary department to replace the tank with a full tank.

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EMERGENCY KIT PROCEDURE

In the event of a medical emergency:

Medical emergency procedure at the Clinic will be handled on a case-by-case basis, but will generally follow the steps outlined below:

1. The person encountering the emergency shall immediately notify the Physician or Mid¬

Level Practitioner and other staff members as warranted.

2. The Physician or Mid-Level Practitioner shall evaluate the emergency and treat the patient as directed in the Protocols. The Physician or Mid-Level Practitioner shall enlist the aid of any of the clinic staff he/she deem necessary. The emergency kit will be issued immediately to the Provider.

3. The Receptionist or Assistant, when instructed, shall immediately call the appropriate

emergency response team and request that an emergency unit be dispatched to the Clinic.

The following emergency units are available depending upon the severity of the patient:

a. EMS/Ambulance (ground and/or air) **Clinic Emergency Number: 911**

4. The phone number for the Poison Center Hotline is (800) 222-1222.

5. When instructed, the receptionist or assistant shall notify the hospital in which the patient is being transferred and request the appropriate Physician or department, as directed by the Physician or Mid-Level Practitioner. The numbers most often used will be:

1. Emergency Room Registration (580) 547-5128

The goal of the Physician or Mid-Level Practitioner is to stabilize the patient for transport to the appropriate facility.

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EMERGENCY KIT ACCESS AND TRAINING

Non-licensed and licensed staff will have access to the Emergency Kit. Non-licensed staff may gather Emergency Kit and supplies but may not administer any medications from the Emergency Kit.

Training for Emergency Kit and Procedures are conducted annually.

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Hand Held Nebulizer

I. PURPOSE

To establish standard guidelines for the administering provider to set-up and perform nebulizer therapy on a patient.

II. POLICY

All Respiratory Care Practitioners (RCP) of the Respiratory Care Department, after demonstration of competence, may perform nebulizer therapy on a patient.

III. PROCEDURE

A. Equipment needed:

1. Nebulizer circuit
2. Aerosol mask

B. Process for nebulizer therapy:

1. Check patients chart and verify order
2. Identify patient by name, birth date, account number
3. Using AIDET begin communication with patient
4. Instruct patient on proper use
5. Assemble nebulizer and add prescribed medication

NOTE: Refer to "Breath Actuated Nebulizer" policy for BAN therapy.

NOTE: RN may administer in PACU and DCS only

6. Set flowmeter at 8-10 liters per minute and nebulizer medication until medicine cup is empty.
7. Remain with patient for duration of therapy.
8. Charge and document therapy.

C. Process for changing out nebulizer circuit:

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1. Nebulizer circuits are to be changed out as needed when visibly soiled or does not function

properly.

D. Process for cleaning:

1. Nebulizer will be disinfected after each use by wiping down with approved disinfectant.

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Functional Medicine Nutrition Assessment

Dr. Nadia Azuero

Patient Name: _____ **Date of Birth:**____/____/____

Today's Date:____/____/____

DIETARY PATTERNS

Current Diet Type: (check all that apply) □ Standard American Diet □ Mediterranean □ Vegetarian □ Vegan □ Paleo □ Ketogenic □ Low-FODMAP □ Gluten-free □ Dairy-free □ Autoimmune Protocol (AIP) □ Intermittent Fasting □ Other: _____

Have you ever followed any special diet in the past? □ Yes □ No If yes, please describe: _____ How long did you follow it? _____ What was the outcome? _____

Food Allergies/Intolerances: (list all known)

_____

_____

Do you have any of the following symptoms after eating certain foods? □ Bloating □ Gas □ Abdominal pain □ Diarrhea □ Constipation □ Headaches □ Brain fog □ Fatigue □ Skin reactions (rash, eczema, etc.) □ Joint pain □ Other: _____

What foods trigger these symptoms? _____

TYPICAL FOOD INTAKE

Please describe what you typically eat in a day:

Breakfast: _____ Time: _____ Location (home, work, car, etc.): _____

Morning Snack: _____ Time: _____ Location: _____

Lunch: _____ Time: _____ Location: _____

Afternoon Snack: _____ Time: _____ Location: _____

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Dinner: _____ Time: _____ Location: _____

Evening Snack: _____ Time: _____ Location: _____

EATING HABITS

How many meals do you eat per day? _____

How many snacks do you eat per day? _____

How many times per week do you eat the following: ___ Home-cooked meals ___ Restaurant meals ___ Fast food ___ Takeout/delivery ___ Processed/packaged foods

Do you skip meals? □ Never □ Occasionally □ Frequently If yes, which ones?

_____

How often do you eat while doing other activities? (watching TV, working, driving, etc.) □ Never □ Occasionally □ Frequently □ Almost always

Do you eat when you are: □ Hungry □ Bored □ Stressed □ Sad □ Happy □ Tired □ Other: _____

Typical portion sizes: □ Smaller than average □ Average □ Larger than average □ Varies greatly

FOOD FREQUENCY

Please indicate how many servings of each you consume in a typical week:

Vegetables: ___ Leafy greens (spinach, kale, lettuce, etc.) ___ Cruciferous (broccoli, cauliflower, cabbage, Brussels sprouts) ___ Root vegetables (carrots, beets, sweet potatoes, etc.) ___ Other vegetables

Fruits: ___ Berries ___ Citrus fruits ___ Apples, pears ___ Tropical fruits ___ Other fruits

Proteins: ___ Red meat (beef, pork, lamb) ___ Poultry ___ Fish/seafood ___ Eggs ___ Legumes (beans, lentils, peas) ___ Tofu/tempeh ___ Nuts/seeds

Grains: ___ Whole grains (brown rice, quinoa, oats, etc.) ___ Refined grains (white bread, pasta, white rice)

Dairy: ___ Milk ___ Cheese ___ Yogurt ___ Other dairy

Fats/Oils: ___ Olive oil ___ Coconut oil ___ Butter/ghee ___ Vegetable/seed oils ___ Avocado

Beverages: (daily intake) ___ Water (8oz glasses) ___ Coffee ___ Tea ___ Soda/soft drinks ___ Diet soda ___ Juice ___ Milk/alternative milks ___ Alcohol ___ Energy drinks ___ Other: _____

Sweets/Treats: (weekly) ___ Desserts ___ Chocolate ___ Candy ___ Baked goods ___ Ice cream ___ Other: _____

Processed Foods: (weekly) ___ Chips/crackers ___ Fast food ___ Frozen meals ___ Canned foods ___ Processed meats (bacon, sausage, deli meat) ___ Other: _____

Condiments/Sauces: (weekly) ___ Salad dressing ___ Ketchup ___ Mayonnaise ___ BBQ sauce ___ Soy sauce ___ Other: _____

HUNGER & FULLNESS

On a scale of 1-10 (1 = starving, 10 = uncomfortably full):

- What level of hunger typically prompts you to eat? _____
- At what level of fullness do you typically stop eating? _____

Do you experience: □ Intense hunger between meals □ Energy crashes between meals □ Feeling shaky or irritable when hungry □ Rarely feeling hungry □ Difficulty recognizing hunger cues □ Difficulty feeling satisfied after eating

CRAVINGS

Do you experience food cravings? □ Yes □ No

If yes, what foods do you typically crave? _____

When do cravings typically occur? □ Morning □ Afternoon □ Evening □ After meals □ During specific situations: _____ □ During specific emotional states: _____ □ Hormonal cycles

How do you typically respond to cravings? □ Ignore them □ Give in completely □ Find a healthier alternative □ Other: _____

DIGESTIVE HEALTH

Do you experience any of the following digestive issues? (check all that apply) □ Heartburn/reflux □ Bloating □ Gas □ Abdominal pain □ Nausea □ Constipation □ Diarrhea □ Undigested food in stool □ Mucus in stool □ Blood in stool

Bowel Movements: Frequency: ___ times per □ day □ week Consistency: □ Hard □ Formed □ Soft □ Loose □ Varies Color: □ Brown □ Black □ Clay/tan □ Green □ Other: _____

Do you take any digestive supplements? □ Yes □ No If yes, please list:

_____

HYDRATION

Daily water intake: ___ 8oz glasses

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Other beverages consumed daily:

_____

Do you drink water with meals? □ Yes □ No

Signs of dehydration you experience: (check all that apply) □ Thirst □ Dry mouth □ Dark urine □ Headaches □ Fatigue □ Dizziness □ Dry skin □ Other: _____

SUPPLEMENTATION

Do you currently take nutritional supplements? □ Yes □ No

If yes, please list all supplements, including brands, dosages, and reason for taking:

Supplement Brand Dosage Frequency Reason Duration

NUTRITION GOALS

What are your nutrition-related goals? (check all that apply) □ Weight loss □ Weight gain □ Improved energy □ Better digestion □ Reduced inflammation □ Manage a health condition □ Sports performance □ Overall wellness □ Other: _____

What nutritional changes are you willing to make? □ Major changes to diet □ Moderate adjustments □ Minor tweaks only □ Unsure

What obstacles might prevent you from making dietary changes? □ Time constraints □ Financial limitations □ Family preferences □ Lack of cooking skills □ Lack of knowledge □ Social situations □ Travel/work schedule □ Food availability □ Other: _____

Have you worked with a nutritionist or dietitian before? □ Yes □ No If yes, what was helpful? _____ What was not helpful?

_____

ADDITIONAL INFORMATION

Is there anything else about your nutrition, eating habits, or relationship with food that you would like to share?

_____

_____

_____

Patient Signature: _____ Date: ____/____/____

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Environmental Exposure Questionnaire

Dr. Nadia Azuero

Patient Name: _____ **Date of Birth:** ____/____/____

Today's Date: ____/____/____

Environmental factors can significantly impact your health. This questionnaire helps us identify potential exposures that might be affecting your wellbeing. Please answer as completely as possible.

HOME ENVIRONMENT

What type of home do you live in? □ Single family house □ Apartment/Condominium □ Mobile home □ Other: _____

Age of your home: _____

How long have you lived at your current residence? _____

Have you recently renovated your home? □ Yes □ No If yes, please describe renovations and when they occurred: _____

Do you have any of the following in your home? (check all that apply) □ Visible mold □ Water damage/leaks (past or present) □ Musty odors □ Carpeting - Age of carpet: _____ □ Gas stove/appliances □ Fireplace/wood stove □ Air purifier - Type: _____ □ Humidifier/dehumidifier □ Pets - Type and number: _____ □ Plants - How many: _____

Heating system: □ Forced air □ Radiator □ Electric □ Wood □ Other: _____

Air conditioning: □ Central □ Window units □ None

How often do you change your air filters? _____

Do you use any of the following? (check all that apply) □ Scented candles/air fresheners □ Essential oil diffusers □ Incense □ Pesticides indoors □ Bleach or ammonia-based cleaners □ "Green" or natural cleaning products □ Fabric softeners/dryer sheets

Do you have concerns about your drinking water? □ Yes □ No Water source: □ City/municipal □ Well □ Filtered □ Bottled

Type of water filter (if any): _____

OCCUPATIONAL EXPOSURES

Current occupation: _____

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Have you been exposed to any of the following at work? (check all that apply) □ Chemicals □ Solvents □ Pesticides □ Mold □ Dust □ Fumes □ Radiation □ Noise □ Vibration □ Extreme temperatures □ Poor ventilation □ Other: _____

Please describe any concerning workplace exposures: _____

_____

Previous occupations with potential exposures:

_____

_____

Do you use personal protective equipment at work? □ Yes □ No □ N/A If yes, please specify:

_____

COMMUNITY ENVIRONMENT

Do you live near any of the following? (check all that apply) □ Industrial facilities □ Agricultural operations □ Major highways □ Power plants □ Waste disposal sites □ Cell phone towers □ High-voltage power lines □ Areas with known air pollution □ Areas with known water contamination □ Other potential environmental hazards: _____

Are you concerned about pollution in your community? □ Yes □ No If yes, please describe:

_____

CHEMICAL EXPOSURES

Have you been exposed to any of the following? (check when and where)

Exposure	Past	Current	Home	Work	Community	Details
Pesticides/Herbicides						
Heavy metals						
Solvents						
Volatile organic compounds						
Mold						
Asbestos						
Radon						
Lead						

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Exposure	Past	Current	Home	Work	Community	Details
Mercury						
Formaldehyde						
Other						

Have you ever had your home tested for any environmental toxins? □ Yes □ No If yes, what were the results? _____

PERSONAL CARE PRODUCTS

Do you regularly use any of the following? (check all that apply) □ Conventional cosmetics □ Conventional hair products □ Conventional deodorant/antiperspirant □ Conventional perfumes/colognes □ Conventional lotions/moisturizers □ Conventional nail polish/removers □ Conventional sunscreen □ "Natural" or "organic" personal care products

On average, how many personal care products do you use daily? _____

REACTIONS & SENSITIVITIES

Do you experience any symptoms when exposed to the following? (check all that apply and describe symptoms)

□ New furniture/carpet: _____ □ Paint/varnish: _____ □ Perfumes/colognes: _____ □ Cleaning products: _____ □ Gas fumes: _____ □ Exhaust: _____ □ Cigarette smoke: _____ □ Certain buildings: _____ □ Public places: _____ □ Specific foods: _____ □ Medications: _____ □ Other: _____

Do your symptoms improve when you leave a particular environment? □ Yes □ No If yes, please explain: _____

Have you been diagnosed with any of the following? □ Multiple Chemical Sensitivity □ Sick Building Syndrome □ Mold illness/CIRS □ Chemical sensitivity □ Environmental illness □ Other related conditions: _____

EXPOSURE HISTORY

Have you ever lived/worked in a water-damaged building? □ Yes □ No If yes, for how long and when? _____

Have you ever been exposed to a chemical spill or toxic release? □ Yes □ No If yes, please describe: _____

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Have you traveled to areas with unique environmental challenges? □ Yes □ No If yes, where and when? _____

Are there specific exposures that you believe have affected your health? □ Yes □ No If yes, please describe: _____

DETOXIFICATION & TREATMENT HISTORY

Have you previously undergone any detoxification treatments? □ Yes □ No If yes, please describe treatments and results: _____

Have you made any changes to reduce your environmental exposures? □ Yes □ No If yes, what changes and what were the results? _____

Are you interested in exploring ways to reduce your environmental exposures? □ Yes □ No

ADDITIONAL INFORMATION

Is there any other information about your environmental exposures that you would like to share?

_____

_____

_____

Patient Signature: _____ Date:____/____/____