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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:		

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.

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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 | HIGH BLOOD PRESSURE |
| HEART DISEASE | HEART DISEASE |
| THYROID DISEASE | KIDNEY DISEASE |
| LIVER DISEASE | ASTHMA |
| BRONCHITIS | STOMACH PROBLEMS |
| ARTHRITIS | ANEMIA |
| GOUT | VITAMIN DEFICIENCY |
| BACK PAINS | NECK PAINS |
| DEPRESSION | PSYCHIATRIC ILLNESS |
| ALCOHOLISM | CHRONIC FATIGUE SYNDROME |
| EATING DISORDER | SLEEP DISORDER |
| FIBROMYALGIA | HEADACHES |
| SEIZURES | CARPEL TUNNEL SYNDROME |
| NEUROPATHY | CANCER |
| STROKE | SENILITY/ DEMENTIA/ ALZHEIMER'S DISEASE |
| MULTIPLE SCLEROSIS | PARKINSON'S DISEASE |
| CEREBRAL PALSY | LEARNING DISORDER |
| MUSCULAR DYSTROPHY | TREMORS |
| HUNTINGTON'S DISEASE | |
| OTHER: LIST BELOW | |

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	ABDOMINAL PAIN
DIFFICULTY CONCENTRATING	NAUSEA AND VOMITING
CONFUSION	DIARRHEA
TROUBLE WITH MEMORY	CONSTIPATION
CHANGE IN PERSONALITY	SKIN RASHES
ANXIETY	UNINTENTIONAL WEIGHT LOSS OR GAIN
DEPRESSION	JOINT PAINS
FATIGUE	SHORTNESS OF BREATH
TROUBLE SLEEPING	CHEST PAINS
HEADACHES	LOSS OF APPETITE
DIZZINESS OR VERTIGO	
VISUAL CHANGES	CHANGE IN WALKING
HEARING CHANGES	TREMORS OR SHAKINESS
DIFFICULTY CHEWING	CHANGES IN HANDWRITING
FACIAL NUMBNESS	CHANGES IN FACIAL EXPRESSION
CHANGE IN ABILITY TO TASTE	DIFFICULTY TURNING IN BED
CHANGE IN ABILITY TO SMELL	NUMBNESS AND TINGLING IN HANDS
CHANGE IN VOICE	NUMBNESS AND TINGLING IN FEET
FAINTING SPELLS	MUSCLE WEAKNESS IN LEGS AND FEET
HEAT INTOLERANCE	MUSCLE TWITCHING OR JERKING
DIFFICULTY WITH SUNLIGHT	COLD FINGERS
LOSS OF BALANCE	LOSS OF SEXUAL INTEREST
DIFFICULTY WITH ERECTIONS (MALE) OR SEXUAL FUNCTION (M OR F)	
OTHER SYMPTOMS: LIST BELOW:	

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 WORSENERD 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?

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.

THANK YOU. JSR