G O N Z A L E Z , Z O L A , W E G M A N & A S S O C I A T E S
A T T O R N E Y S A T L A W , A . P . C .
6 0 0 H A M P S H I R E R D , S U I T E # 2 0 1
W E S T L A K E V I L L A G E , C A 9 1 3 6 1

CITY, TOWN OF TONAWANDA, GRAND ISLAND, KENMORE, AND RIVERSIDE

CLIENT RESIDENCE AND ILLNESS QUESTIONNAIRE

Please answer each of the questions as best you can. It is very important that your answers be as complete as possible. You must answer every question. If you do not know the answer to a question, please write "**I do not know**". Please do not leave any questions blank. If you need additional space for your answers please use **additional sheets** located at the end of the questionnaire. Remember, a questionnaire must be completed for each member of your family. If minor children involved, please fill out a questionnaire for **each** child.

1. CURRENT INFORMATION

Name: _____ First Middle Last _____

Address: _____ Street Address Apt No. _____

_____ City State Zip Code _____

Phone: _____ Home Work Cell _____

E-mail: _____

Date of Birth: _____ Month/Day/Year _____

DO YOUR RENT OR OWN YOUR PROPERTY (PLEASE CIRCLE ONE)

YES **NO**

Please list all previous addresses.

FROM Month/Day/Year	TO Month/Day/Year	STREET ADDRESS	CITY	STATE	ZIP CODE	OWN/ RENT

a. **Do you now or have you ever had a private groundwater well on this property?**
_____
_____

b. **Have you experienced breathing discomfort, watery eyes, or skin irritations while at this property?** _____
_____

c. **Have you ever grown fruits or vegetables on this property? If so, when, what kind and how often did you grow them?** _____
_____
_____

d. **Have you been diagnosed with a lung or blood disorder? If so, what type?** _____
_____
_____

2. MEDICAL INFORMATION

a. CANCER

If you have been diagnosed with any type of cancer, please list them below.

Type of Cancer	Date of Diagnoses	Current Treatment Status
	Month/Day/Year	
	Month/Day/Year	
	Month/Day/Year	

b. NON-CANCER HEALTH PROBLEMS

Please list down all past and current health issues.

Illness/Condition	Treated by a Physician or Medical Facility?	When did the problem begin?	Current Health Status:
		Month/Day/Year	
		Month/Day/Year	
		Month/Day/Year	
		Month/Day/Year	
		Month/Day/Year	
		Month/Day/Year	

c. PRESCRIBED MEDICATIONS:

Have you taken any medication(s), prescribed or not, as a result of injuries you've already listed? ___ Yes. ___ No.

If yes, please fill out the following:

Medication Name:	**Medication used for what treatment/illness**	**Date Medication prescribed:**	**Ongoing usage of medication? "Yes" or "No"**	**Doctor who prescribed it:**
		Month/Day/Year		
		Month/Day/Year		
		Month/Day/Year		
		Month/Day/Year		
		Month/Day/Year		

3. ADDITIONAL HEALTH QUESTIONS

Do you drink alcoholic beverages (including beer)? _____ Yes _____ No

If yes, check one of the choices for now and in the past:

Now:	**In the Past:**
_____ Daily	_____ Daily
_____ Several Times a Week	_____ Several Times a Week
_____ Monthly	_____ Monthly
_____ Seldom	_____ Seldom
_____ Never	_____ Never

Have you ever smoked cigarettes? _____ Yes _____ No

If yes, age you started smoking: _____

If you have quit for good, age you stopped smoking: _____

What is the most you smoked per day on a regular basis, (**number of packs**): _____

Do you smoke?

Cigars _____ Yes _____ No

A pipe _____ Yes _____ No

*For the following questions, Answer whether or not (**within the last twelve months**) you have experienced any of the following conditions. For example, if you have the problem about half the time you would mark the circle in the middle.*

Do your hands shake (tremors)?	Never ○○○○○○○○○○ Always
Headaches?	Never ○○○○○○○○○○ Always
Do the headaches ever get worse at work?	Never ○○○○○○○○○○ Always
Do the headaches feel like a tight band around your head?	Never ○○○○○○○○○○ Always
Lightheadedness?	Never ○○○○○○○○○○ Always
Dizziness?	Never ○○○○○○○○○○ Always
Do you have spells of drowsiness?	Never ○○○○○○○○○○ Always
Headaches with nausea?	Never ○○○○○○○○○○ Always
Do you have any numbness in your arms?	Never ○○○○○○○○○○ Always
Do you have any numbness in your legs?	Never ○○○○○○○○○○ Always
Do you have high blood pressure?	Never ○○○○○○○○○○ Always
Do you have chest pain when at rest?	Never ○○○○○○○○○○ Always
Do you have chest pain on exertion?	Never ○○○○○○○○○○ Always
Chest tightness?	Never ○○○○○○○○○○ Always
Palpitations/rapid heart action?	Never ○○○○○○○○○○ Always
Throat irritation?	Never ○○○○○○○○○○ Always
Do you have heartburn?	Never ○○○○○○○○○○ Always
Cough with mucous?	Never ○○○○○○○○○○ Always
Dry cough?	Never ○○○○○○○○○○ Always
Does your chest sound wheezing or whistling?	Never ○○○○○○○○○○ Always
Shortness of breath?	Never ○○○○○○○○○○ Always
Are you troubled by shortness of breath when resting?	Never ○○○○○○○○○○ Always
Decreased alcohol tolerance?	Never ○○○○○○○○○○ Always
Poor bladder control?	Never ○○○○○○○○○○ Always
Abdominal pain?	Never ○○○○○○○○○○ Always
Do your feet or ankles swell up?	Never ○○○○○○○○○○ Always
Do you have decreased libido (low sex drive)?	Never ○○○○○○○○○○ Always

*For the following questions, Answer whether or not (**within the last twelve months**) you have experienced any of the following conditions. For example, if you have the problem about half the time you would mark the circle in the middle.*

Do you have skin redness?	Never ○○○○○○○○○○ Always
Do you have excessive drying or itching of the skin?	Never ○○○○○○○○○○ Always
Have you had a lot of hair fall out suddenly?	Never ○○○○○○○○○○ Always
Extreme fatigue (tiredness)?	Never ○○○○○○○○○○ Always
Somnolence (unusual need for sleep)?	Never ○○○○○○○○○○ Always
Insomnia (can't fall asleep)?	Never ○○○○○○○○○○ Always
Insomnia (wake up frequently)?	Never ○○○○○○○○○○ Always
Insomnia (sleep soundly for only a few hours)?	Never ○○○○○○○○○○ Always
Lack of concentration (distracted easily)?	Never ○○○○○○○○○○ Always
Recent memory loss?	Never ○○○○○○○○○○ Always
Long-term memory loss ?	Never ○○○○○○○○○○ Always
Instability of mood (rapid mood changes)?	Never ○○○○○○○○○○ Always
Do you have a skin rash?	Never ○○○○○○○○○○ Always
Do you have vision blurred or do your eyes burn?	Never ○○○○○○○○○○ Always
Eye irritation (frequent blinking and tearing)?	Never ○○○○○○○○○○ Always
Sinusitis (sinus infections)?	Never ○○○○○○○○○○ Always
Runny nose?	Never ○○○○○○○○○○ Always
Does you nose get stuffed?	Never ○○○○○○○○○○ Always
Does your nose itch?	Never ○○○○○○○○○○ Always
Do you get nosebleeds?	Never ○○○○○○○○○○ Always
Reduced sense of smell?	Never ○○○○○○○○○○ Always
Indigestion?	Never ○○○○○○○○○○ Always
Stomach swells or bloated?	Never ○○○○○○○○○○ Always
Diarrhea?	Never ○○○○○○○○○○ Always
Constipation?	Never ○○○○○○○○○○ Always
Nausea?	Never ○○○○○○○○○○ Always
Loss of appetite?	Never ○○○○○○○○○○ Always

QUESTIONS OR CONCERNS

Please use this section to provide us with additional information

_____
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_____
_____
_____
_____

I am responding on my own behalf:

Print Name: First Middle Last

Signed Name: Sign here

Dated: Month/Day/Year

If you are responding in behalf of another person (for example a minor), please fill out the following:

Relationship:_____

Name: First Middle Last

Address: Street Address Apt No.

City State Zip Code

Phone: Home Work Cell