

**PESTICIDE EPISODE INVESTIGATION NON-OCCUPATIONAL EXPOSURE SUPPLEMENT**

PR-ENF-128 (Est. 12/03)

Page 1 of 2

NAME OF PERSON INTERVIEWED	ADDRESS (Number and Street, City, State, ZIP Code)
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TELEPHONE NUMBER (Include Area Code)	COUNTY	DATE OF EXPOSURE	TIME OCCURRED <input type="checkbox"/> AM <input type="checkbox"/> PM
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EXPOSURE SITE <input type="checkbox"/> HOUSE <input type="checkbox"/> APARTMENT <input type="checkbox"/> SCHOOL <input type="checkbox"/> VEHICLE TYPE _____ <input type="checkbox"/> RETAIL <input type="checkbox"/> OPEN AREA <input type="checkbox"/> OTHER _____	NUMBER EXPOSED OUTDOORS _____	IS EXPOSURE ONGOING? <input type="checkbox"/> YES <input type="checkbox"/> NO
	NUMBER EXPOSED INDOORS _____	

DID ANYONE SEE A DOCTOR? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY SAW A DOCTOR? _____	NAME OF DOCTOR/MEDICAL FACILITY _____
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ADDRESS OF DOCTOR/MEDICAL FACILITY (Number and Street, City, State, ZIP Code)	TELEPHONE NUMBER (Include Area Code)
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DATE(S) PERSONS SAW A DOCTOR _____	WAS ANYONE HOSPITALIZED? IF "YES", HOW MANY PERSONS? IF "YES", LENGTH OF STAY (DAYS) <input type="checkbox"/> YES <input type="checkbox"/> NO
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LOCATION OF EXPOSURE - BE SPECIFIC. USE PAGE 2, IF NEEDED; ATTACH A MAP, IF DESIRED.

DESCRIBE HOW EXPOSURE OCCURRED. DESCRIBE LOCATION, ACTIVITIES, WHAT HAPPENED, WHAT WAS SEEN, HEARD, SMELLED, TASTED, AND FELT. USE PAGE 2, IF NEEDED.

NAME OF PERSONS EXPOSED IN BUILDING (CONTINUE LIST ON PAGE 2, IF NECESSARY)	GENDER (M/F)	DATE OF BIRTH (OR AGE)	SYMPTOMS EXPERIENCED	HAVE SYMPTOMS RESOLVED?
(SPACE 1 IS FOR PERSON BEING INTERVIEWED)				
1			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
2			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
3			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
4			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
5			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
6			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
7			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
8			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO

PESTICIDE ALLEGEDLY INVOLVED	REGISTRATION NUMBER FROM LABEL	COMMODITY/SITE TREATED
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PERSON/FIRM ALLEGEDLY RESPONSIBLE	OWNER OR OPERATOR OF PROPERTY TREATED
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INVESTIGATOR'S NAME (PRINT)	INVESTIGATOR'S SIGNATURE	TITLE	DATE
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**PESTICIDE EPISODE INVESTIGATION NON-OCCUPATIONAL EXPOSURE SUPPLEMENT**

PR-ENF-128 (Est. 12/03) (Reverse)

NAME OF PERSONS EXPOSED IN BUILDING (CONTINUE LIST ON SEPARATE PAGE, IF NECESSARY)	GENDER (M/F)	DATE OF BIRTH (OR AGE)	SYMPTOMS EXPERIENCED	HAVE SYMPTOMS RESOLVED?
9			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
10			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
11			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
12			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
13			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
14			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO
15			<input type="checkbox"/> EYES BURN/TEAR <input type="checkbox"/> NOSE IRRITATION <input type="checkbox"/> COUGH <input type="checkbox"/> DIZZY <input type="checkbox"/> SORE THROAT <input type="checkbox"/> SHORT BREATH <input type="checkbox"/> RASH/ITCH <input type="checkbox"/> ODOR <input type="checkbox"/> HEADACHE <input type="checkbox"/> VOMIT/NAUSEA <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO

CONTINUATION OF REMARKS (EXPOSURE LOCATION, HOW EXPOSURE OCCURRED)

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INVESTIGATOR'S NARRATIVE

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PLOT MAP

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