



Property Address: _____
 _____ Zip _____

Date of survey: _____

Home Environmental Assessment Form

For use at initial home visit (Baseline)

General Information

Comments

How many people live here? _____ How many are < 6 yrs old? _____ Do any children < 6 yrs visit or play here? <input type="checkbox"/> Yes <input type="checkbox"/> No How many are between 7 and 17 yrs old? _____	
Have you made any home improvements in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No What was done to the home?	
In the past 6 months, has there been a fire in this home? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what was the cause of the fire?	
Proximity Road- Number of block to major road: _____	
Ownership status: <input type="checkbox"/> Own <input type="checkbox"/> Rent Type of Home: <input type="checkbox"/> Single <input type="checkbox"/> Duplex <input type="checkbox"/> 4-plex <input type="checkbox"/> Multi large <input type="checkbox"/> Trailer	

General Home Conditions

Comments

Do you ever use a space heater in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you ever use your kitchen stove for heat? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you aware of any of the following: <input type="checkbox"/> Water leaks <input type="checkbox"/> Broken windows	
Have you noticed any of the following in the home: <input type="checkbox"/> Mold <input type="checkbox"/> Rodents <input type="checkbox"/> Rodent nests <input type="checkbox"/> Rodent droppings <input type="checkbox"/> Cockroaches <input type="checkbox"/> Cockroach feces <input type="checkbox"/> Holes in walls/floors related to rodents or insects	

Lifestyle and Living Space

Comments

Does anyone who lives in the home smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many smokers are there? _____ Where do they smoke? <input type="checkbox"/> Outside <input type="checkbox"/> Inside <input type="checkbox"/> Both Do they use a smoking jacket? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do visitors smoke in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often are they here? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month <input type="checkbox"/> Infrequently	
Do you burn candles or incense in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use room fresheners in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<p>How often do you dust your home?</p> <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month <input type="checkbox"/> Infrequently	
<p>Does your family have any pets?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: What type of pets? <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Bird <input type="checkbox"/> Rodents <input type="checkbox"/> Reptile <input type="checkbox"/> Fish Is the aquarium kept covered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____ How many pets (total number) are there? _____ Where are pets allowed to be in your home? _____ Where do your pets sleep? _____ Where do you store the pet food? _____ Do you remove the pet food and water each night? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Home and Child Safety

Comments

<p>Do you have smoke detectors in the home?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Do you have a carbon monoxide detector in the home?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	

General Family Health (Persons OTHER than the child with asthma)

<p>In the past 6 months, has any one else in your family experienced:</p> <input type="checkbox"/> frequent cough without a cold About how often _____ <input type="checkbox"/> breathing difficulties About how often _____ <input type="checkbox"/> runny nose About how often _____ <input type="checkbox"/> itchy eyes About how often _____ <input type="checkbox"/> skin rash or irritation About how often _____ <input type="checkbox"/> persistent stomach aches About how often _____ <input type="checkbox"/> headache/nausea/dizziness About how often _____	
<p>In the past 6 months, how many times have persons in your family stayed home from work or school because of illness? _____ times</p>	
<p>In the past 6 months, about how many days were other persons in your family sick? _____ times</p>	
<p>In the past 6 months has any one else in your family been:</p> <input type="checkbox"/> hospitalized # of times _____ <input type="checkbox"/> received care in an emergency room # of times _____ <input type="checkbox"/> received care in an urgent care center # of times _____ <input type="checkbox"/> had an appointment with a doctor because of illness # of times _____	
<p>Family History of Asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	