

Health Questionnaire

For Past & Current Residents of Northport, WA and Surrounding Communities

Name: _____

Current Address: _____

Phone number(s): _____

E-mail Address: _____

Birthdate: _____ Birthplace: _____

If you are living in or near Northport now, how long have you been a resident?

Total Years: _____

From: _____ (year) To: _____ (year or current)

Address of your home(s) in (or around) Northport:

If you are NOT a resident of Northport now, how long did you live in Northport or the surrounding communities?

Total Years: _____

From: _____ (year) To: _____ (year or current)

Address of your home(s) in (or around) Northport:

What is your occupation (type of work)? _____

If no longer a resident of Northport what was your occupation when you were living there? _____

Have you worked in any of the following industries (check all that apply)?

Smelter	_____	Metal Plating	_____
Microelectronics	_____	Metal processing	_____
Wood (preservatives)	_____	Plastics	_____
Automotive	_____	Battery (auto)	_____
Plumbing	_____	Ceramics	_____
Pest control	_____	Stained glass	_____
Farm (herbicides)	_____	Demolition (houses)	_____
Coal	_____	Mining	_____

Have you worked in a job where you were exposed to arsenic, cadmium, lead or mercury?

Yes _____ No _____

If yes, what was your occupation, where, what years?

Did you play at the old LeRoi Smelter site, or remove scrap material, wood and/or bricks while living in Northport, etc.?

Yes _____ No _____

If yes, please provide approximate years & time spent there and/or items took from site

SPECIFIC HEALTH ISSUES

How would you rate your overall health?

Excellent _____ Good _____ Fair _____ Poor _____

Please put a check by any health issues/illnesses you have been diagnosed with or think you may have.

If you are submitting a form for a deceased family member please provide year of death under correct category.

IBD (Inflammatory Bowel Disease)

Crohn's Disease _____

Ulcerative Colitis _____

Ileitis _____

Diverticulitis _____

Other _____

Year symptoms began _____

Year you were diagnosed _____

ARTHRITIS

Type of arthritis (e.g., rheumatoid) _____

Year symptoms began _____

Year you were diagnosed _____

KIDNEY ISSUES

Nephritis _____

Other _____

Year symptoms began _____

Year you were diagnosed _____

BLADDER ISSUES

Frequent Bladder Infections _____

Vesicoureteral Reflux _____

Other _____

Year symptoms began _____

Year you were diagnosed _____

CANCER

Kidney _____

Stomach _____

Colon _____

Brain _____

Bladder _____

Breast _____

Eye _____

Skin _____

Thyroid _____

Prostate _____

Pancreas _____

Uterine _____

Other _____

Year symptoms began _____

Year you were diagnosed _____

CENTRAL NERVOUS SYSTEM DISORDERS

Multiple Sclerosis _____

Fibromyalgia _____

Parkinson's disease _____

Other: _____

(Including tingling and numb sensations/symptoms)

Year symptoms began _____

Year you were diagnosed _____

BRAIN DISEASES

Alzheimer's _____

Aneurism _____

Tumors _____

Cysts _____

Other _____

Year symptoms began _____

Year you were diagnosed _____

HEART OR VASCULAR DISEASES

Heart _____

If yes, please provide specific issue(s): _____

Stroke _____

Other _____

Year symptoms began _____

Year you were diagnosed _____

BIRTH DEFECTS / PREGNANCY

Were you born with, or did you have a child born with, any birth defects?

Yes _____ No _____

If yes, please explain defect(s):

(If more space needed please use other side)

Year child was born _____

Were you born with, or did you have a child born with colic and/or jaundice?

Colic _____

Jaundice _____

Year child was born _____

Other _____

Have you ever had a miscarriage(s) while living in Northport?

Yes _____ No _____

If yes, Year(s) of miscarriage(s): _____

ENDOCRINE & METABOLIC DISORDERS

Thyroid Disorder _____

Type (e.g., hyper, enlarged) _____

Adrenal Disorder _____

Type (e.g., Addison's) _____

Fluid Concentration _____

Type (e.g., calcium, magnesium) _____

Metabolic Disorder _____

Type (e.g., gauchers) _____

Pituitary Disorder _____

Type _____

Year symptoms began _____

Year you were diagnosed _____

Diabetes _____

Type 1 _____ Type 2 _____

Year symptoms began _____

Year you were diagnosed _____

Have any of your children been diagnosed with a thyroid issue?

Yes _____ No _____

If yes, please list type _____

Childs DOB _____

Year symptoms began _____

Year they were diagnosed _____

SLEEP DISORDERS

Narcolepsy _____

Insomnia _____

Sleep Apnea _____

Year symptoms began _____ Year you were diagnosed _____

ALLERGIES

Allergies _____

Type:

Year symptoms began _____ Year you were diagnosed _____

Sinus Issues _____

Year symptoms began _____ Year you were diagnosed _____

Migraines _____

Year symptoms began _____ Year you were diagnosed _____

FOOD ALLERGIES

Celiac Disease _____

Cushing's _____

Candida _____

Gluten _____

Year symptoms began _____ Year you were diagnosed _____

LEARNING DISABILITIES

ADD/ADHD _____

Dyslexia _____

Other _____

Year symptoms began _____ Year you were diagnosed _____

SKIN DISORDERS

Melasma _____

Year symptoms began _____ Year you were diagnosed _____

Chloasma _____

Year symptoms began _____ Year you were diagnosed _____

Dark spots/discolorations _____

If yes, please describe (body area, basic description)

Year symptoms began _____

Other Health Issues not listed above:

(If more space needed use the back of this page)

Major Surgeries: (if related to above e.g., removal of large intestine/colon, cysts, tumors, etc.)

Year of Surgery _____

Does anyone in your family suffer from Ulcerative Colitis or Crohn’s Disease?

Yes _____ No _____

If yes, please list relationship and age when diagnosed:

Does anyone in your family suffer from cancer?

Yes _____ No _____

If yes, please list type of cancer (be as specific as possible):

Have you ever had any testing done for heavy metal toxins?

Yes _____ No _____

If yes, please list test type (hair, urine, blood) and any high or low levels found

Would you be willing to have a hair sample tested for heavy metals?

(Even if you already have in the past)

Yes _____ No _____

If yes, please put how you prefer to be contacted you regarding this:

E-mail: _____

Phone: _____

Address: _____

Where to return questionnaire:

Please return this questionnaire as soon as possible.

Via E-Mail: Paparichj@live.com and/or Northportproject@hotmail.com

Via Mail: **Jamie Paparich, 5013 Snowy Mtn. Drive Winnemucca, NV 89445**

Please contact me if you know of someone who did not received one and is interested in participating, or if you think they are a candidate. Feel free to give them my e-mail or phone number and do not hesitate to call or e-mail me as well with any questions or concerns.

Cell phone: 775-750-6384

E-mail: paparichj@live.com

Thank you!

FOR MORE INFORMATION VISIT THE NORTHPORT PROJECT BLOG AT:

<http://northportproject.wordpress.com/>