THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Toxin Exposure Questionnaire (TEQ-20)

Patient Name_____ Date_____

Please check YES or NO for each of the following questions. Your provider will discuss your answers with you.

QUESTIONS	YES	NO
1. Do you consume conventionally grown (non-organic) fruits and vegetables regularly? If so, which ones do you eat most often? _____	☐	☐
2. Do you consume conventionally raised animal products (meat, dairy, eggs) regularly? If so, which ones do you eat most often? _____	☐	☐
3. Do you consume fish or seafood more than twice a week? If so, please describe what you eat and whether it is farmed or wild. _____	☐	☐
4. Do you consume fast foods, canned/packaged foods, soda, or foods with artificial colors, flavors, preservatives or sweeteners more than three times a week?	☐	☐
5. Have you lived in a mobile home, boat, or RV, or a very old or brand-new home? If so, please describe: _____	☐	☐
6. Have you recently been exposed to new construction materials or furniture (e.g., paint, laminate flooring, particle board, new carpeting, bedding, furniture, etc.)?	☐	☐
7. Does your home or workplace have cracking paint or decaying insulation or foam, visible mold, water damage, or damp windows, basement, or crawlspaces?	☐	☐
8. Are you often exposed to adhesives, paints, flea treatments, varnishes, solvents, welding/soldering materials, or other air-borne chemicals at home or work?	☐	☐
9. Have you been exposed to treated lumber, lead paint, paint chips or dust, broken mercury thermometers or fluorescent bulbs, or other toxic substances you know of?	☐	☐
10. Do you drink water from a well, spring, or cistern, or from plumbing pipes or fixtures installed before 1986?	☐	☐
11. Do you regularly use conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or work?	☐	☐
12. Are your health concerns related to time spent living or working adjacent to a highway, factory, incinerator, gas station, power plant, or other industrial pollution source?	☐	☐
13. Have you lived in an agricultural area or often been exposed to herbicides, pesticides, fungicides at home, work, parks & golf courses, or roadsides?	☐	☐
14. Do you live near a cell phone tower, high-voltage power lines, or other known source of electromagnetic radiation?	☐	☐
15. Do you live or work in a sealed building with recirculated air or a building that has wood, propane, or gas stoves or appliances?	☐	☐
16. Do you smoke or are often exposed to second-hand smoke, fly often, or run or bike to work along busy streets?	☐	☐
17. Are you highly sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes? If so, please explain: _____	☐	☐
18. Have you had root canals, tooth extractions, "silver" fillings, crowns, dental sealants, dentures, retainers, aligning trays, braces, mouth guards, dental implants, etc.?	☐	☐
19. Have you had any unusual reactions to anesthesia or to prescription or over-the-counter medications? If so, please describe: _____	☐	☐
20. Do you have a history of heavy use of alcohol or recreational or prescription drugs? If so, please describe or discuss with your provider: _____	☐	☐