Odor and Symptom Log

Complete a form EACH time you smell an odor. Form must include address/location where you smelled the odor.

Name ________________________

Contact Information Phone _____________ E-Mail ____________

Location/Address where odor was observed_________________

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Date _______________

Time you noticed odor ____________________________

Time odor stopped ________________________________

Is odor ongoing Yes ___ No ___

Describe Odor ____

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Describe Possible Source of Odor _____________________

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Describe Wind Speed and Direction (check TV Weather)

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Are there any new activities occurring in the area?

Yes _____ No __________

Describe the new activities__________________________________

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Symptoms

Did your health change or get worse when you smelled the odor?

Yes ___ No ___

Describe the symptoms:

___ Headache
___ Sore Throat
___ Burning or Watering Eyes
___ Blurred Vision
___ Skin Irritation
___ Nose Irritation
___ Ear Pain
___ Lung Irritation
___ Wheezing
___ Difficulty Breathing
___ Respiratory Impacts
___ Sinus Problems
___ Dizziness
___ Lightheadedness
___ Fatigue
___ Asthma Attacks
___ Coughing
___ Nose Bleeds
___ Tremors
___ Muscle Aches
___ Joint Pains
___ Abdominal Pain
___ Nausea
___ Vomiting
___ Weakness
___ Sleep Disorder
___ Asthma
___ Mood Changes
___ Behavioral Impacts
___ Stress

Other Health Symptoms ___________________________________
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Other Observations____
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Return form to: