

# Patient Questionnaire



NAME: \_\_\_\_\_  
(First) (Middle) (Last)

SSN: \_\_\_\_\_  
DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

Parent/Guardian (if applicable) \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Other (Cell, Work) ( ) \_\_\_\_\_

Do you have any **family members** who have ever been patients here? \_\_\_\_\_ If so, who: \_\_\_\_\_

Have you ever had allergy skin testing or received allergy injections in the past? \_\_\_\_\_

Were you **referred by a physician**? \_\_\_\_\_ If YES:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

Do you have a **PRIMARY CARE PHYSICIAN**? \_\_\_\_\_ If YES:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

Please list all **CURRENT MEDICATIONS**, including non-prescription, vitamins, herbal, etc.

MEDICATION	STRENGTH	DOSAGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION	STRENGTH	DOSAGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all **MEDICINE ALLERGIES** or INTOLERANCES.

MEDICATION	REACTION/SYMPTOMS
_____	_____
_____	_____
_____	_____

**PHARMACY NAME:** \_\_\_\_\_  
Phone # \_\_\_\_\_

**Are your immunizations up to date?** \_\_\_\_\_

Please give a brief description of the **PRINCIPLE REASON** you are here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature of patient/responsible individual:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**CHECK THOSE BOXES WHICH RELATE TO YOUR SYMPTOMS:**

**Nasal Symptoms:**

- Sneezing
- Nasal discharge
  - (watery)
  - (mucus)
  - (yellow)
  - (blood-tinged)
- Nasal stuffiness
  - (relieved by meds)
  - (varies with change in environment)
  - (changes with seasons)
- Itching
- Dryness
- Nose bleeds
- Snoring
- Mouth breathing

**Sinus Symptoms:**

- Sinus pressure
- Sinus pain
- Headaches
  - (sharp/stabbing)
  - (throbs/pounds)
  - (dull/aching)
  - (lasts 1-3 days)
  - (more than a week)
  - (present on awakening)
  - (recurs at same time)
  - (particular seasons)
  - (worse with weather changes)
- (preceded by aura)

**Eye Symptoms:**

- Itch
- Water
- Swollen
- Dry
- Scratchy

**Ear Symptoms:**

- Popping
- Pressure
- Earache
- Fullness

- Ringing
- Recurrent childhood infections
- Recent ear infections

**Throat Symptoms:**

- Sore throat
- Hoarseness
- Itching
- Lump in throat
- Tightness
- Throat clearing
- Phlegm in throat

**Asthma/Lung Symptoms**

- Wheezing
- Shortness of Breath
  - (awakens at night)
- Cough
  - (dry)
  - (continuous)
  - (during day)
  - (during night)
  - (coughing up sputum)
  - (wheezy cough)
  - (hacking cough)
  - (loose cough)
  - (non-productive)
- Chest tightness
- Difficulty breathing
  - (chronic)
  - (acute)
  - (new onset)
  - (laying down)
  - (sitting up)
  - (worse at night)
  - (environmental exposures)

**Skin Symptoms:**

- Itching
  - (generalized)
  - (localized)
  - (scalp)
  - (palms and soles)
- Dry Skin
  - (chronic)
  - (generalized)
  - (localized)

- (hands)
- (face)
- (creases)
- (feet)
- Cracking
- Rash
- Redness

**Stinging Insects:**

- Allergy to:
  - (bee)
  - (wasp)
  - (hornet)
  - (yellow jacket)
  - (ants)
  - (other)

**Food Allergy**

- Allergic reaction from ingested food
  - Allergy to:
    - (milk)
    - (wheat)
    - (seafood)
    - (fish)
    - (shellfish)
    - (soy)
    - (peanuts)
    - (nuts)
    - (eggs)
    - (chocolate)
    - (multiple)
  - Food Intolerance:
    - (fatty foods)
    - (milk)

**Miscellaneous:**

- Complaint of Allergic Reaction
- Complaint of allergic reaction from contact
- Complaint of allergic reaction seasonal
- Complaint of allergic reaction from inhalation
- Complaint of recurrent infection

**CHECK THOSE BOXES WHICH RELATE TO YOUR SITUATION:**

**PAST MEDICAL HISTORY:**

- Surgeries/Hospitalizations
- Previous Emergency Room Visits for asthma
- Previous Emergency Room Visits for Allergic reactions
- Previous Emergency Room Visits – other
- No prior serious illnesses

**SOCIAL HISTORY:**

***Activities/Hobbies:***

- Sports**
- Recreational**
- (outdoors)
- (gardening/yard work)
- (painting/woodworking)
- (arts and crafts)

***Work Environment:***

- Occupation**
- (homemaker)
- (office worker)
- (outdoor worker)

***Smoking History***

- Never Smoked**
- Quit**
- Smoke cigarettes**
- (for \_\_\_\_ packs-years)
- (greater than 50 pack-year)
- Cigars \_\_\_\_ day**
- Pipe**

***Alcohol History:***

- Social Drinker**
- Moderate Drinker**

**ENVIRONMENT HISTORY:**

***Home:***

- City/Country**
- Private Residence**
- (owned)
- (rented)
- Apartment**

***Pets:***

- Indoors**
- Dogs**
- Cats**

***Flooring:***

- Carpet**
- Hardwood**
- Tile**

***Bedroom:***

- Feather pillow**
- Synthetic pillow**
- Standard mattress**
- Waterbed mattress**
- Tempurpedic mattress**
- Uses mattress encasements**
- Uses pillow encasements**
- No encasements**

***Heating/Air conditioning:***

- Central heat**
- Space heaters**
- Fireplace**
- No heating**
- Central air conditioning**
- No air conditioning**

***Tobacco Smoke in home:***

- Smoker**
- Second-hand smoke in home**

**CHECK THOSE BOXES WHICH RELATE TO YOUR SITUATION:**

**FAMILY HISTORY:**

***Mother's History***

- Good Health
- Environment Allergies
- Asthma
- Severe Allergic Reactions
- Recurrent Infections
- Deceased

***Father's History***

- Good Health
- Environment Allergies
- Asthma
- Severe Allergic Reactions
- Recurrent Infections
- Deceased

***Brother/Sister History***

- Good Health
- Environment Allergies
- Asthma
- Severe Allergic Reactions
- Recurrent Infections
- Deceased

**REVIEW OF SYSTEMS:**

***General Health***

- Feeling fine
- Fever
- Chills
- Night Sweats
- Recent change in weight
- Lethargy

***Heart:***

- Chest pain
- Palpitations
- Murmur
- Ankle swelling

***ENT:***

- Loss of hearing
- Ringing in ears
- Crooked nose
- Mouth sores

***GI:***

- Nausea
- Vomiting
- Heartburn
- Difficulty swallowing

- Abdominal pain
- Constipation
- Diarrhea
- Change in stools

***GU:***

- Urinary infections
- Loss of urinary control
- Urinary stones
- Painful urination
- Blood in urine

***Bone & Joint:***

- Joint pains
- Joint swelling
- Joint stiffness
- Muscle weakness
- Back pain

***Skin:***

- Lesions
- Dry skin

- Itching
- Sensitivity to sunlight

***Neurologic:***

- Fainting
- Dizziness
- Headaches
- Decreased concentration
- Convulsions

***Endocrine:***

- Excessive thirst
- Temperature intolerance
- Excessive eating
- Frequent weight changes

***Psychiatric:***

- Mood changes
- Energy level changes
- Behavior changes
- Sleep disturbances