



Patient Questionnaire

NAME: _____

SSN: _____

(First) (Middle) (Last)

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:

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

NAME: _____

NAME: _____

ADDRESS: _____

ADDRESS: _____

PHONE NUMBER: _____

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/SYMTOMS	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