PATIENT QUESTIONNAIRE

Patient Name:	Account No.:
Referring Physician:	Appt. Date:
Primary Care Physician:	

INSTRUCTIONS: **Please answer the following questions as thoroughly as possible. A complete, accurate record is vital for treatment of your allergy problems. Bring this completed form to your first appointment.**

1. REASON FOR VISIT:

Briefly describe the reason for your visit and what you hope to accomplish

2. NASAL/SINUS PROBLEMS:

Indicate your history of nasal/sinus problems (none, leave blank)

Circle any SYMPTOMS you experience:

Hay fever	Dental pain/pressure	Nasal blockage	Halitosis (bad breath)	Headache
Itchy nose	Facial pain/pressure	Postnasal drip	Decreased sense of smell	Fever
Runny nose	Itchy eyes	Ear pain/pressure	Sinus infections	Sneezing

Other (add any not listed): _____

Circle any TRIGGERS for your symptoms:	Animals	Season change
Cutting/playing in grass, raking leaves	Strong odors, fumes or perfumes	High winds
Physical exertion or exercise	Mold/mildewed areas or items	Cold weather
Sweeping, dusting or vacuuming	Smog, smoking or smoke exposure	Other outdoor exposure
Air conditioning or heating	Other (add any not listed) _____	

When did your NASAL/SINUS problems begin?

YES	**NO**	**VISIT A DOCTOR for your NASAL/SINUS problem?**	Physician:	Year:
YES	**NO**	**Have you had SINUS X-RAYS done?**	Facility:	Year:
YES	**NO**	**Have you had SINUS SURGERY?**	Physician:	Year:

YES NO EVER TAKEN MEDICATIONS (PRESCRIPTION, OVER-THE-COUNTER OR HERBAL) FOR *NASAL/SINUS PROBLEM* ?

MEDICATION NAME	DOSE	HOW OFTEN TAKEN	HELPFUL?

3. CHEST PROBLEMS:

Indicate your history of chest problems (none, leave blank)

Circle any SYMPTOMS you experience:

Cough	Shortness of breath	Shortness of breath with exercise	Wheezing

Other (add any not listed): _____

Circle any TRIGGERS for your symptoms:	Animals	Season change
Cutting/playing in grass, raking leaves	Strong odors, fumes or perfumes	High winds
Physical exertion or exercise	Mold/mildewed areas or items	Cold weather
Sweeping, dusting or vacuuming	Smog, smoking or smoke exposure	Other outdoor exposure
Air conditioning or heating	Other (add any not listed) _____	

When did your CHEST problems begin?

YES	**NO**	**VISIT A DOCTOR for your CHEST problem?**	Physician:	Year:
YES	**NO**	**Have you had CHEST X-RAYS done?**	Facility:	Year:

YES NO EVER TAKEN MEDICATIONS (PRESCRIPTION, OVER-THE-COUNTER OR HERBAL) FOR *CHEST PROBLEM* ?

MEDICATION NAME	DOSE	HOW OFTEN TAKEN	HELPFUL?

4. SKIN PROBLEMS:

Indicate your history of skin problems (none, leave blank)

Circle any SYMPTOMS you experience:

Hives Swelling Itchiness Rash Redness

Other (add any not listed): _____

Circle any TRIGGERS for your symptoms:	Animals	Season change
Cutting/playing in grass, raking leaves	Strong odors, fumes or perfumes	High winds
Physical exertion or exercise	Mold/mildewed areas or items	Cold weather
Sweeping, dusting or vacuuming	Smog, smoking or smoke exposure	Other outdoor exposure
Air conditioning or heating	Other (add any not listed) _____	

When did your SKIN problems begin?

YES	**NO**	**VISIT A DOCTOR for your SKIN problem?**	Physician:	Year:
YES	**NO**	**EVER TAKEN MEDICATIONS (PRESCRIPTION, OVER-THE-COUNTER OR HERBAL) FOR *SKIN PROBLEM* ?**		

MEDICATION NAME	DOSE	HOW OFTEN TAKEN	HELPFUL?

5. ALLERGY REACTIONS:

Indicate any history of ALLERGIC REACTIONS (none, leave blank)

Allergic reaction to a MEDICATION?			
Medication:	Year:	Reaction:	Treatment:
Medication:	Year:	Reaction:	Treatment:
Medication:	Year:	Reaction:	Treatment:
Medication:	Year:	Reaction:	Treatment:
Allergic reaction to INSECT STING?			
Insect:	Year:	Reaction:	Treatment:
Allergic reaction to a FOOD?			
Food:	Year:	Reaction:	Treatment:
Food:	Year:	Reaction:	Treatment:
Food:	Year:	Reaction:	Treatment:
Reaction to a DENTAL work?	Year:	Reaction:	Treatment:

6. OTHER MEDICAL PROBLEMS:

Indicate any OTHER MEDICAL PROBLEMS experienced or diagnosed

YES	**NO**	**Diabetes**	**YES**	**NO**	**Cystic fibrosis**
YES	**NO**	**Heartburn/Reflux/GERD**	**YES**	**NO**	**Pneumonia**
YES	**NO**	**High blood pressure**	**YES**	**NO**	**Cough up blood**
YES	**NO**	**Heart trouble**	**YES**	**NO**	**Liver Trouble**
YES	**NO**	**Migraine headaches**	**YES**	**NO**	**Kidney Trouble**
YES	**NO**	**Frequent nose bleeds**	**OTHER MEDICAL PROBLEMS (add any not listed):**		
YES	**NO**	**Ear infections**			
YES	**NO**	**Thyroid**			

7. SURGERY & HOSPITALIZATION HISTORY:

List all HOSPITALIZATIONS/SURGERIES and reason

LIST MOST RECENT FIRST	YEAR	REASON FOR HOSPITALIZATION OR SURGERY

8. FAMILY MEDICAL HISTORY:		Indicate if any FAMILY MEMBERS HAVE HISTORY of these illnesses	
DO IMMEDIATE FAMILY MEMBERS HAVE A HISTORY OF?			IF YES, WHO (e.g. mother, father, siblings, children, etc.)?
YES	NO	Asthma	
YES	NO	Hay fever	
YES	NO	Eczema	
YES	NO	Hives	
YES	NO	Sinus problems	
YES	NO	Frequent infections	
YES	NO	Headaches	
YES	NO	Immune deficiency	
YES	NO	Emphysema or other lung disease	
YES	NO	Cystic fibrosis	

9. CURRENT MEDICATIONS:	List ALL CURRENT MEDICATIONS (prescription, over-the-counter, herbal, vitamin)	
MEDICATION NAME	DOSE	HOW OFTEN TAKEN
PREFERRED PHARMACY:		

10. ENVIRONMENTAL HISTORY:		Indicate if you experience any of these ENVIRONMENTAL FACTORS								
YES	NO	Do you presently smoke or have you ever smoked?	Number of years:		Number per day:		Quit time:			
YES	NO	Does anyone who lives with you smoke?								
YES	NO	Do you drink alcohol?	How much and how often?:							
YES	NO	Do you have pets or animals at home?								
		Type:	Number:		Indoor?	Yes	No	Spend time in the bedrooms?	Yes	No
		Type:	Number:		Indoor?	Yes	No	Spend time in the bedrooms?	Yes	No
YES	NO	Do you work? What type of work do you do?:								
YES	NO	Is there a history of any water damage or indoor mold in your home?								
YES	NO	Do you have dust covers on your mattress and/or pillow?								

Other information you'd like the provider to know:

11. REVIEW OF SYSTEMS:	**Indicate if you CURRENTLY experience any problems**	
ORGAN SYSTEM	**CIRCLE ONE**	**If YES, please circle all symptoms that apply:**
General health:	**YES NO**	Fatigue, fever, chills, malaise, night sweats, decreased appetite
Eyes:	**YES NO**	Itching, redness, discharge, dryness, excessive tearing
Ears:	**YES NO**	Pressure or fullness, pain, ringing, decreased hearing, frequent ear infections, dizziness, itching
Nose:	**YES NO**	Sneezing, itching, runny nose, congestion, nosebleeds, mouth breathing, post nasal drip, snoring, dryness
Sinus:	**YES NO**	Pressure, pain, discolored discharge, decreased smell, halitosis
Throat:	**YES NO**	Post nasal drip, frequent throat clearing, hoarseness, soreness, itching
Respiratory:	**YES NO**	Cough, wheezing, shortness of breath, chest tightening
Skin:	**YES NO**	Hives, rash, itching, swelling
Cardiovascular:	**YES NO**	Chest pain, palpitations, swelling of feet or legs
Gastrointestinal:	**YES NO**	Heartburn, vomiting, diarrhea, stomach pain
Genitourinary:	**YES NO**	Frequent urination, pain with urination, incontinence
Musculoskeletal:	**YES NO**	Joint pain, stiffness
Neurology:	**YES NO**	Headache, vertigo, lightheadedness
Psychiatry:	**YES NO**	Anxiety, depression