

ALLERGY AND ASTHMA MEDICAL - PATIENT QUESTIONNAIRE

Dear Patient,

Please answer the following medical questions. *Please be reassured that patient privacy is a top priority!*

Name: _____ Date of Birth _____ Today's Date: _____

Reason for Visit? _____

Have you ever had any of these medical problems in addition to the reason for your visit?

(please check all that apply)

Check Here, If No Past Medical Problems.

CARDIOVASCULAR:	<input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Elevated Cholesterol <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack
EAR/NOSE/THROAT:	<input type="checkbox"/> Cataracts <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Nasal Polyps <input type="checkbox"/> Tinnitus	<input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Recurrent Acute Tonsillitis <input type="checkbox"/> Vertigo
GASTROINTESTINAL:	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver Disease	<input type="checkbox"/> Hernia (Hiatal)	<input type="checkbox"/> GERD (Gastroesophageal Reflux)
GENTOURINARY:	<input type="checkbox"/> Prostate Enlargement <input type="checkbox"/> Hernia	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Acute Renal Failure
HEMATOLOGIC:	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Anemia	
INFECTIOUS DISEASE:	<input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Bronchitis	<input type="checkbox"/> Mononucleosis <input type="checkbox"/> Pneumonia	<input type="checkbox"/> STD Type: _____
OTHER:	<input type="checkbox"/> Autoimmune Disease Type _____		
METOBOLIC/ENDOCRINE:	<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Thyroid Deficiency (Hypothyroidism)	<input type="checkbox"/> Thyroid Excess (Hyperthyroidism)
CANCER:	<input type="checkbox"/> YES	Enter Type: _____	Enter Type: _____
NEUROLOGIC:	<input type="checkbox"/> Migraines <input type="checkbox"/> Seizures	<input type="checkbox"/> Other Disorder (Parkinson's, Alzheimers, ALS, MS): Enter Type: _____	<input type="checkbox"/> Stroke <input type="checkbox"/> Neuropathy
OBSTETRIC:	<input type="checkbox"/> Complications During Pregnancy	<input type="checkbox"/> Complications During Delivery	<input type="checkbox"/> Preterm Birth
PSYCHIATRIC:	<input type="checkbox"/> Adjustment Disorder - Anxiety	<input type="checkbox"/> Major Depressive Disorder	
PULMONARY:	<input type="checkbox"/> Asthma <input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> COPD	<input type="checkbox"/> Tuberculosis

MEDICAL PROBLEMS NOT LISTED ABOVE:

_____/_____/_____

_____/_____/_____

_____/_____/_____

For any indicated Medical Problem above, was surgery performed (fill in as much information as possible)?

Date or Age: _____ Treatment/Surgery: _____ Where: _____ Physician: _____

Date or Age: _____ Treatment/Surgery: _____ Where: _____ Physician: _____

Date or Age: _____ Treatment/Surgery: _____ Where: _____ Physician: _____

Name: _____ Date of Birth _____

Medications:

List medications and vitamins that you take on a regular basis.
(Please include Supplements, Homeopathic, Herbal, Over The Counter Medicines,
Topical Medications, Nasal Sprays and Inhalers)

Medication: _____ Dosage(if known): _____ Medication: _____ Dosage(if known): _____
 Medication: _____ Dosage(if known): _____ Medication: _____ Dosage(if known): _____
 Medication: _____ Dosage(if known): _____ Medication: _____ Dosage(if known): _____
 Medication: _____ Dosage(if known): _____ Medication: _____ Dosage(if known): _____
 Medication: _____ Dosage(if known): _____ Medication: _____ Dosage(if known): _____
 Medication: _____ Dosage(if known): _____ Medication: _____ Dosage(if known): _____

Allergies:

Do you have any of the following Food (please check all that apply)?
 Check Here, If No Known Food Allergies.

<input type="checkbox"/> Milk	<input type="checkbox"/> Eggs	<input type="checkbox"/> Soy	<input type="checkbox"/> Finned Fish
<input type="checkbox"/> Crustacean Shellfish	<input type="checkbox"/> Mollusk Shellfish	<input type="checkbox"/> Tree Nuts	<input type="checkbox"/> Peanuts
<input type="checkbox"/> Wheat	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

Do you have any of the following Environmental (please check all that apply)?
 Check Here, If No Known Environmental Allergies.

<input type="checkbox"/> Cats	<input type="checkbox"/> Dogs	<input type="checkbox"/> Dust	<input type="checkbox"/> Mold
<input type="checkbox"/> Weed Pollen	<input type="checkbox"/> Grass Pollen	<input type="checkbox"/> Tree Pollen	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

Do you have any of the following Drug Allergies (please check all that apply)?
 Check Here, If No Known Drug Allergies.

<input type="checkbox"/> Ace Inhibitors	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Macrolides (eg. azithromycin)
<input type="checkbox"/> Sulfas	<input type="checkbox"/> IV Contrast	<input type="checkbox"/> NSAIDS (Tylenol/Advil/Ibuprofen)	<input type="checkbox"/> Penicillins
<input type="checkbox"/> Tetracyclines	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

Social History:

Do you, or have you ever smoked?

<input type="checkbox"/> Current Every Day Smoker	<input type="checkbox"/> Never Smoker
<input type="checkbox"/> Current Some Day Smoker	<input type="checkbox"/> Smoker, Current Status Unknown
<input type="checkbox"/> Former Smoker	<input type="checkbox"/> Unknown if Ever Smoked

Do you drink alcohol (please check)?

<input type="checkbox"/> Rarely or Never	<input type="checkbox"/> Drink Daily
<input type="checkbox"/> Occasionally (Social)	<input type="checkbox"/> Former Alcohol Intake, None For _____ Years.

Are you presently or have you ever been exposed to a second hand smoke hazard?

<input type="checkbox"/> No	<input type="checkbox"/> Yes – (circle one, or both) Presently Past
-----------------------------	---

Do you consume caffeine?

<input type="checkbox"/> Yes (Fill-in): Coffee (how many cups/day)? _____ Tea (how many cups/day)? _____ Other Beverage(s) – Type: _____	<input type="checkbox"/> No
--	-----------------------------

Residence Type?

Any Pets?

<input type="checkbox"/> Apartment <input type="checkbox"/> House <input type="checkbox"/> Other specify): _____	<input type="checkbox"/> Cats <input type="checkbox"/> Dogs <input type="checkbox"/> Other specify): _____, _____
---	--

Flooring?

Any Construction?

<input type="checkbox"/> Hardwood Flooring <input type="checkbox"/> Bedroom Carpeting <input type="checkbox"/> Bedroom Area Rugs	<input type="checkbox"/> New Construction <input type="checkbox"/> Basement Apartment <input type="checkbox"/> Musty Environment <input type="checkbox"/> Water Damage
---	---

HEPA or Special Air Filter in Your Residence?

<input type="checkbox"/> No	<input type="checkbox"/> Yes
-----------------------------	------------------------------

Your Profession/Job:

Your Hobbies/Activities/Sports:

Please Fill-in: _____	Please Fill-in: _____
-----------------------	-----------------------

Family History (Please Place Check Marks):

<u>RELATION:</u>	C	P	G	O
<u>FAMILY HISTORY</u> <u>OF:</u>	H	A	R	T
	I	R	A	H
	L	E	N	R
	D	N	P	R
	T	T	A	E
	R	A	R	L
	E	R	E	A
	N	T	N	T
	T	T	T	I
	T	T	T	V
	T	T	T	E
ADD-Attention Deficit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVA (Stroke)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines (Common)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please enter if anyone in your family (child, parent, grandparent, sibling, other relative) has had the Same or Similar problem(s) as the reason for your visit:

Problem: _____ Family Member(s): _____

Problem: _____ Family Member(s): _____

Problem: _____ Family Member(s): _____

“Review of Systems”:

Put a check next to medical issues you currently have, fill in “Other”,

OR check “No Problems” :

Constitutional: No Problems Fever Chills Night Sweats Dizziness

Other: _____

Cardiovascular: No Problems Chest Pain Swelling of Extremities High Blood Pressure

Other: _____

Endocrine: No Problems Thyroid Problem Diabetes

Other: _____

Eyes: No Problems Blurry Vision Double Vision Itchiness Blindness Photophobia

Other: _____

Gastrointestinal: No Problems Nausea Vomiting Bleeding Liver Problem Diarrhea

Other: _____

Genitourinary: No Problems Bleeding Burning Kidney Stones Prostate Problem

Other: _____

Hematologic: No Problems Easy Bruising Anemia Clotting Problem

Other: _____

Immunologic: No Problems HIV Positive AIDS

Other: _____

Lymphatic: No Problems Nodes Lumps

Other: _____

Musculoskeletal: No Problems Pain Swelling Weakness Stiffness Arthritis

Other: _____

Neurological: No Problems Numbness Memory Problems Vertigo

Other: _____

Ob/Gyn (females only): No Problems Pregnant Irregular Periods Discharge

Other: _____

Psychiatric: No Problems Depression Anxiety Hallucinations Suicidal Tendency Drug Addiction

Other: _____

Respiratory: No Problems Asthma Pneumonia Cough Sputum Wheezing Tuberculosis

Other: _____

Skin: No Problems Rash Lesion Pain

Other: _____