

PATIENT QUESTIONNAIRE

Please fill out this form completely

Patient Name _____ DOB _____

Primary Care Physician: _____ Referred by: _____

Other family members seen in our office _____

Current Medications-(Please look at bottle or packaging as many names sound and are spelled similarly. Use a separate sheet of paper if necessary)

Medication Name	Dose	How often	Duration Taken

Other Allergy Medication Tried or used in the past	Name	Did it work? Y/N

Medication Allergies **No Known Drug Allergies**

Drug Name	Reaction	When?

Past Medical History/Problems: *(check all that apply)*

<input type="checkbox"/> Asthma	<input type="checkbox"/> Deafness	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> CANCERS
<input type="checkbox"/> Angina	<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Head/Neck
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Lung
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> MEN ONLY	<input type="checkbox"/> Breast
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Stomach
<input type="checkbox"/> Broken Bone	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> WOMEN ONLY	<input type="checkbox"/> Colon
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Gout	<input type="checkbox"/> Stroke	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Liver
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Lymphoma
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Other GYN issues	<input type="checkbox"/> Leukemia

Personal Medical History:

Have you ever seen an allergist before? Yes No Who? _____
Have you ever had allergy skin testing? Yes No When? _____
Have you ever been given allergy shots? Yes No When? _____

Please list any surgeries you have had: _____

Do you smoke: Y N If yes, how much? _____ How long? _____

Does anyone else smoke in your home? Y N

Do you drink alcohol? Y N If yes, how many per week? Beer Wine Liquor

Have you ever had an allergic reaction to a food? Y N What? _____

Have you ever had an allergic reaction to an insect bite? Y N When? _____

OTHER HISTORY:

Occupation: _____

Are you exposed to any chemicals or fumes at work? Y N What? _____

Do you have any pets in your home? Y N What? _____

Do you have mold or mildew in your home? Y N

Do you have air conditioning? Y N Do you have a basement? Y N

Do other family members have allergies? _____

Have you recently had any of the following? (Check all that apply, if in doubt, leave blank)

GENERAL

- Fatigue
- Weight loss
- Weight Gain
- Night sweats
- Fever
- Sleep apnea
- Recurrent Infections

SKIN

- Rash
- Hives
- Itching
- Swelling
- Bruising

EYES

- Itching
- Dryness
- Eye pain
- Red eyes
- Vision Changes

NOSE

- Bloody Nose
- Congestion
- Runny Nose
- Sinus Infections
- Polyps

EARS

- Ear infections
- Hearing loss
- Ringing
- Vertigo

MOUTH/THROAT

- Sore Throat
- Lip Swelling
- Tongue Swelling
- Throat Itching

ENDOCRINE

- Tremor
- Heat/Cold Intolerance

BLOOD

- Easy Bleeding
- Bruising

HEART/LUNGS

- Wheezing
- Shortness of Breath
- Persistent cough
- Bronchitis
- Frequent Pneumonia
- Palpitations
- Chest Pain
- Heart Murmur
- High Blood Pressure

**STOMACH/
INTESTINES**

- Heartburn
- Nausea
- Upset stomach
- Vomiting
- Abdominal Pain
- Diarrhea
- Constipation

GENITOURINARY

- Urinary Tract Infections
- Blood in Urine
- Incontinence

OB/GYN

- Vaginal Infections
- Estrogen Therapy
- Number of Children _____

MUSCULOSKELETAL

- Joint Pain
- Joint Swelling
- Muscle weakness

**NEUROLOGIC/
MENTAL HEALTH**

- Headaches
- Seizures
- Numbness/Tingling
- Depression
- Nervousness
- Anxiety