ROCKY MOUNTAIN ALLERGY • ASTHMA IMMUNOLOGY at Tanner Clinic

2121 North 1700 West
Layton, UT 84041
Ph 801.773.4840

5296 S Commerce St.
Suite 104
Murray, UT 84107
Ph 385.261.2410

Instructions: Please answer the following questions as completely and accurately as possible. The parent should fill out the form for patients under the age of 15.

NEW PATIENT QUESTIONNAIRE

Today's Date _____

Patient's Name _____ DOB _____ Sex: M F

How did you hear about our clinic or who were you referred by? _____

Reason for Allergy visit (briefly describe): _____

_____

A. Please check the conditions that have bothered you in the last 12 months:

Nose:
___ Stuffy
___ Sneezing
___ Itching
___ Draining
___ Bleeding
___ Mouth breathing
___ Snoring
___ Loss of smell
___ Frequent sinus infections

Eyes:
___ Itching
___Burning
___Watering
___ Swelling

Throat:
___ Itching
___ Draining
___ Throat clearing
___ Soreness
___ Hoarseness
___ Loss of Taste

Ears:
___ Itching
___ Popping
___ Draining
___ Ringing
___ Hearing Loss
___ Fluid behind eardrums
___ Frequent ear infections

Respiratory:
___ Cough
___ Wheeze
___ Shortness of Breath
___Tightness
___ Phlegm (mucus)
___ Bronchitis
___ Pneumonia

Gastrointestinal
___ Abdominal pain
___ Vomiting
___ Diarrhea
___ Constipation
___ Poor appetite
___ Poor weight gain
___ Heartburn/acid reflux

Nervous System:
___ Headache
___ Unusual tiredness
___ Irritability

Skin:
___ Hives
___ Itch
___ Swelling

Musculoskeletal:
___ Muscle pains
___ Joint pains

Cardiovascular:
___ Heart racing
___ Chest pain

Constitutional:
___ Fevers

Allergy:
___ Food allergy

Endocrine:
___ Heat/cold intolerance

Other symptoms not listed above: _____

_____

_____

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History of Present Illness:

	Nose/Eye	Chest	Skin
When did these symptoms begin (year)?	_____	_____	_____
Where did these symptoms begin (state)?	_____	_____	_____
When did these symptoms occur last (date)?	_____	_____	_____
What time of day are these symptoms worse?	_____	_____	_____

Underline the month(s) your symptoms occur. Circle the months that are worst.

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

B. What medications or treatments have you taken in the past for your allergies and/or asthma?

	Helpful? Yes	No		Helpful? Yes	No
1. _____	___	___	5. _____	___	___
2. _____	___	___	6. _____	___	___
3. _____	___	___	7. _____	___	___
4. _____	___	___	8. _____	___	___

C. Please list all your current medications and reasons for taking them:

D. Have you ever been on allergy shots (immunotherapy)? If yes, when, for how long, and to what?

Past Medical History

E. Please list any medication allergies including a description of any reactions:

F. Please list any past or current medical problems not yet mentioned above, including any surgeries:

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G. Please list any medical problems that run in your immediate family:

Relationship (mother, brother, daughter, etc.)

Asthma: _____
Hay Fever or Allergic Rhinitis: _____
Eczema: _____
Immunodeficiency of any type: _____

Any other medical problems in the family:

_____ _____
_____ _____
_____ _____

H. Personal History:

Do you smoke? _____ How many packs per day? _____ How Long have you smoked? _____

Does anyone smoke at home or work? _____

Do you have any pets? If yes, type (cat dog, etc.) and number.

_____

What is your occupation? _____

What is your exercise routine? _____

If the patient is a young child, does he/she attend daycare? _____

Signature _____ Date _____