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New Patient Questionnaire

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.

Today's Date____________________

Patient's Name____ DOB___________ Sex: M / F / Other

Primary Care Provider______________________________ Phone number____________________

Preferred Pharmacy_________________________ Address/Phone ___________________________

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:
___Congestion
___Sneezing
___Running
___Itching
___Nasal Polyps
___Bleeding
___Loss of smell
___Frequent sinus infections
___Snoring

Eyes:
___Itching
___Tearing
___Swelling
___Redness
___Styes

Ears:
___Itching
___Blockage
___Infections
___Draining
___Hearing loss
___Ear aches

Throat:
___Itching
___Hoarseness/voice loss
___Infections
___Post nasal drip
___Soreness
___Bad breath
___Dryness

Respiratory:
___Asthma
___Cough
___Wheeze
___Phlegm (mucus)
___Tightness
___Shortness of breath
___Pneumonia
___Congestion
___Bronchitis

Gastrointestinal:
___Abdominal pain
___Nausea
___Vomiting
___Diarrhea
___Constipation
___Poor appetite
___Poor weight gain
___Heartburn/acid reflux

Nervous system:
___Headache
___Unusual tiredness
___Irritability

Skin:
___Eczema
___Hives
___Itching
___Swelling
___Flushing

Musculoskeletal:
___Muscle pains
___Joint pains
___Hyper flexibility

Cardiovascular:
___Heart racing
___Chest pain

Constitutional:
__ Fevers
__Immunodeficiency

Allergy:
__Food allergy
__Pollen
__Animals

Endocrine:
__Heat/cold intolerance

Other symptoms not listed above:____

____

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	Helpful no		Helpful yes	Helpful 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:

____
____
____
____

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? Yes / No

Type (cat, dog, etc.)	How many?	Kept Inside or Outside?	Allowed in patient's bedroom?
________________	_________	Indoors / Outdoors	Yes / No
________________	_________	Indoors / Outdoors	Yes / No
________________	_________	Indoors / Outdoors	Yes / No

What is your occupation? ____

What is your exercise routine? ____

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

Signature____ Date________________