Gupta ENT Center
Ear, Nose & Throat | Head & Neck Surgery | Pediatric & Adult

New Patient Testing Questionnaire

Patient:___________________________________ Appt. Date:__________________ Time:_____________

Please review and answer questions below. Bring this back with you on your scheduled appointment time above.

1. Please check the symptoms you most frequently experience:

Chest	**Sinus**	**Nose**	**Throat**	**Eyes**	**Ears**
□ Breathless	□ Infections	□ Sneezing	□ Sore	□ Itching	□ Infections
□ Wheezing	□ Pressure	□ Itching	□ Itching	□ Tearing	□ Itching
□ Cough	□ Pain	□ Runny	□ Postnasal Drip	□ Swelling	□ Popping
□ Chest tight	□ Headache	□ Congested	□ Trouble swallowing	□ Infections	□ Pain
		□ Decreased smell/taste			□ Decreased hearing

2. Do you get hives? □ Yes □ No
3. Do you have eczema? □ Yes □ No
4. When did your symptoms first begin? ____
5. Please check anything that you think causes or worsens your symptoms:

Outdoors	**Indoors**	**Other**
□ Weather changes	□ Dusting/vacuuming	□ Strong smells
□ Fall pollen	□ Bedroom	□ Smoke
□ Spring pollen	□ Bathroom	□ Animals
□ During/after rainfall	□ Attic/basement	□ Workplace/school
□ Dry days	□ Kitchen	□ Food
□ Windy days	□ A/C or heating system	□ Other______________________________

6. When do your symptoms occur?
□ Happened only once □ Persistent (year round) □ Random (no pattern) □ Worse in certain seasons: Winter Spring Fall Summer

7. How have your symptoms been treated in the past?
□ Antibiotics □ Antihistamines □ Decongestants □ Nasal Sprays □ Allergy Injections

8. Do you experience any symptoms after eating certain foods? □ Yes □ No
If yes, please explain____

9. *Bee Venom Allergy*: Have you ever had a severe reaction after a sting? □ Yes □ No
Describe reaction(s):____

10. *Drug Allergy,* describe reaction*:*____

11. Smoke cigarettes □ Yes □ No How much?_________ For how long?________ Quit □ When_______
Number of indoor smokers at home________________

12. *Home:* □ Single House □ Townhouse □ Apartment □ Basement/crawl space □ Concrete slab
Age of home______________ years

13. *Heating/AC*: Check all that apply: □ Gas □ Electric □ Wood □ Forced Air □ Radiant □ Humidifier □ Central A/C □ Window A/C □ Air cleaner

14. *Bedroom:* Check all that apply: □ Water Bed □ Standard Bed □ Comforter □ Feathers/Down □ Blanket/Afghan □ House plants □ Wall to wall carpet

15. *Pets:* □ Yes □ No □ Dog □ Cat □ Other___________________ How many indoors?________________
Are pets allowed in your bedroom? □ Yes □ No