We realize this form is long but filling it out completely will help us to diagnose and treat your condition. Thank you in advance.

PATIENT QUESTIONNAIRE

How would you like the Doctor and office staff to address you by? __________________

Last	First	Middle	Age	Occupation	Brithdate

Address	Home Tel.	Work Tel.

Mother' Name (Adults omit)	Age	Occupation	Cell phone	email
Father' Name (Adults omit)	Age	Occupation	Primary Care Doctor	Who referred you?

1. LIST MAIN COMPLAINTS, STARTING WITH THE ONE THAT CONCERNS YOU THE MOST

	Age of onset
A.	
B.	
C.	

2. START AT THE BEGINNING AND DESCRIBE YOUR ILLNESS. Please give as many details as you can.

3. ARE YOUR SYMPTOMS **Present all year?** Yes No **How often?** Daily Most of the time Occasionally
Worse during certain months? Yes No **Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec**

4. WHAT MAKES SYMPTOMS WORSE? (Circle)

Food	Infections	Raking leaves	Mostly indoors	Other animals
Drugs	High humidity	Barns	Mostly outdoors	Cutting the grass
Aspirin	Dampness	Fatigue	Occupation	Air Conditioning
Cosmetics	Cold air	Exercise	School	Windy days
Visiting homes	Weather changes	Stress / Emotion	Rubber	Winter
Odors	Basements	Menstrual period	Laughter	Spring
Alcoholic beverages	Musty odors	Mornings	Cats	Summer
Cigarette smoke	Dust or Dusting	Nighttime	Dogs	Fall

OTHER:

5.WHAT IMPROVES SYMPTOMS?

Medication	Daytime
Winter	Nighttime
Spring	Allergy injections
Summer	Away from home
Fall	Vacations
Rest	Air Conditioning

OTHER:

6. MEDICATIONS: List **ALL** medications you are *now* on for whatever reason. Include past Rx that you were given for your problem. **If answer is Yes, Please √ in the appropriate boxes**	**Helped?**	**On now?**	**Taken always?**	**Side effects? Describe**

7. EVER SEEN BY ALLERGIST? Yes No **Allergy Shots?** When and how long? **Help?** Yes No **Major reactions?** Yes No

System Review *Do you now have or have you ever had....Circle items that you have now and underline those that you had at one time and do not have now*

How is your general health? Excellent Fair Poor

Fainting Spells | Always tired | Eat lots of junk food
Bruise easily | General weakness | Frequent aches & pains
Chills/fever | Change in weight | Change in appetite
Eat a balanced diet | Always thirsty

Head Symptoms
Absent Present How long?______________________

1. Nose
Head colds: how many in past year____

Frequent sneezing | Fullness of sinuses | Nasal rubbing
Runny nose | Yellow/green discharge | Nose bleeds
Stuffy nose | Sinus headaches | Itchy nose
Pressure when bending | Dry nose | Poor sense of smell

2. Ears
Hearing loss | Pain | Congestion
Popping | Ringing | Frequent ear infections
Plugging | Fullness | Itchy
Drainage What color___________

3. Eyes
Watery | Itchy | Burning
Eyelid Puffiness | Redness | Blurred vision
Double vision | Change in vision | Dryness
Painful | Gritty feeling (like sand)

4. Throat
Postnasal drip…Thick? Thin? Colored at times?

Clearing of throat | Cough from drip? | Tooth pain
Itch at roof of mouth | Bad breath | Hoarseness
Poor sense of taste | Frequent sore throats | Funny taste in mouth
Glands swollen | Difficulty swallowing | Snoring

5. Do you use nose sprays or drops? Yes No
If Yes What name(s)______________________________________

6. Do you take blood pressure pills? Yes No

Lungs
Shortness of breath | Wheezing | Heaviness in chest
Tightness in chest | Night cough

Coughing/wheezing…
____After exercise
____After laughter/stress
____When lying down at night
____Nighttime awakenings due to cough/wheeze
____How many times per night?
____How many nights per week?

Cough is? Dry Loose Bring up sputum
Sputum production (Color_____________________)
Night sweats | Cough up blood

Heart
Murmur | Irregular Pulse | Palpitations
Large leg veins | Swollen ankles | Chest discomfort w exercise

Abdomen
Jaundice | Constipation | Nausea
Vomiting | Diarrhea | Distension
Frequent belching | Heartburn | Acid taste in mouth
Indigestion | Bowel habit change | Cramping
Rectal pain w bowel movement
Changes in ...____Bowel habits ___Color of stool

Extremities
Swelling of legs | Joint swelling/Pain | Discoloration
Cold hands/feet | Blue/purple hands

Genito-Urinary tract
Pain/burning on urinating
Discolored urination | Bed wetting
Other ____________________________

Women
GYN problems | Pain on menstruation | Breast discharge
Lump in breast | Bleeding between periods
Age of menses____ | Menses every____days
Lasts for ____days | Menopause began____ended _______
Deliveries______ | Miscarriages______
Birth control method_________# of pregnancies______

Men
Difficulty w erection | Prostate problems
Weak urine stream

Neurological
Frequent headaches | Convulsions | Fainting
Dizziness | Anxiety | Lightheadedness
Room seems spinning | Mood swings | Balance problems
Loss of consciousness | Leg or arm weakness | Muscle spasms
Muscle strength loss | Visit mental health professional
Tingling of extremities | Uncontrollable tension
Change in sensation of hands or feet

Glandular
Constant thirst | Very sluggish
Excessively nervous | Change in hair or skin texture
Excessive getting up at night to go to urinate
Always seem ___cold ___hot when everybody else is comfortable

Skin
Hives | Itchiness | Rashes
Dryness | Easy bruising | Poison Ivy
Insect bite severe | Insect sting reactions | Skin infections

Do you have a food intolerance? Explain
____
____
____
____
____
____

Did we miss anything?
____
____
____
____
____
____

Have you seen any other doctors recently for current or related reasons?

Name	Date	Reason

Medical History: **Place a √ (Omit children's section if over age 12)**

ALL PATIENTS	No	Yes Now	Yes Past	Date/ Age		No	Yes Now	Yes Past	Date/ Age		No	Yes Now	Yes Past	Date/ Age
Eye diseases					Hepatitis					Seizures				
Glasses Contacts					Liver Disease					Nervous breakdown				
Ear diseases (Name)					Hemorrhoids/rectal problems					Poor blood clotting				
Recurrent ear infections					Colon or bowel disease					Anemia (Type)				
Recurrent throat infections					Gastroesophageal reflux					Headaches				
Recurrent sinusitis					Hiatal hernia Other hernias					Migraine headaches				
Nasal Polyps					Diabetes					Other				
Recurrent colds					Thyroid Disease									
Nasal allergy					Arthritis					**CHILDREN**				
Asthma					Gout					Birth Wt Lb Oz				
Frequent bronchitis					Broken bones					Pregnancy—Normal 9 month				
Bronchiectasis					Kidney infection					Complicated delivery				
Pneumonia					Kidney stones					Newborn respiratory distress				
Emphysema					Osteoporosis					Breast fed — How long				
C.O.P.D.					Eczema					Colic or vomit				
Tuberculosis Pos.TB test					Other skin diseases					Infancy — trouble with food				
Other lung diseases					Hives					Infancy — Poor weight gain				
Angina					Anaphylaxis					Infancy — Frequent infections				
Murmur					Food allergy					Immunizations complete				
Heart attack					Mononucleosis					Normal development(sit etc)				
High__Low__blood pressure					Chronic fatigue syndrome					Overactive				
Mitral Valve Prolapse					Syphilis or other venereal dis.					Attention deficit Syndrome				
Irregular heart beat					Significant emotional problem					Dyslexia				
Varicose veins					Anxiety					Convulsions				
Phlebitis					Depression					Mental retardation				
Stomach or duodenal ulcer					Severe Insect sting reaction					Croup often				
Gall stones					Transfusions					Significant problem w school				
Irritable bowel syndrome					Cancer or Tumor									

Drug Reactions: Please list

Date/Age	Drug	Reaction	Taken since? Y	N

Hospitalizations: List all hospitalizations or operations regardless of reasons

Date/Age	Problem or Operation	Hospital & Location

Family History: Please note family members with the following diseases

	AGE	HEALTH			DEATH		Asthma	Nasal Allergy	Immune deficiency	Eczema	Drug allergy	Insect allergy	Food allergy	Hives	Mental illness	Cancer	Diabetes	High blood pressure	Arthritis	Heart disease	Thyroid disease	Other	
		Good	Fair	Poor	Age	Cause																	
Mother																							
Father																							
Brother(s)																							
Sister(s)																							
Mother's mother																							
Mother's father																							
Father's mother																							
Father's father																							
Your spouse																							
Your children																							

PERSONAL HISTORY *Circle or answer where appropriate. Some answers may not apply. Some questions may seem very personal but are are designed to find out if they might have any effect on your medical problems.* ***Answers will be kept in the strictest of confidence.***

1. **Tobacco:** Ever smoke? Yes No ____ Pkgs/cigars/pipes per day for ____ yrs. Age started ____ Age stopped ____
2. **Alcoholic beverages:** Never Rarely Regularly Weekends How many per week & what kind
3. **Ever take illegal drugs?** Yes No What kind and when ______________________________
4. **Average hours sleep** Drink: coffee / tea ______cups per day
5. **Exercise:** Regularly Occasionally Rarely What kind? ______________________________
6. **What do you like to do in your spare time?** ______________________________
7. **Marital status:** M S D W If married, how many years _____ Have you been divorced? Yes No
8. **Education:** Highest grade or degree ___________ What grade or year are you now in? _______
9. **Children:** Please give age, sex. Start with the oldest ______________________________
10. **How do you generally consider yourself? anxious nervous easy going compulsive must get things right easily upset**
11. **Do you think that you have a lot of stress in your life?** Yes No Home Workplace Financial Other
12. **Do you think stress might affect your illness?** Yes No Have you ever thought of seeking psychological help Yes No
13. **WORKPLACE**: What is your job? ______________________________ Do you feel you have any increased symptoms at work?

____
____
____
____

HOME ENVIRONMENT

Age of home _____ How long lived there _____ What kind of home? 2 story ranch apartment (____rooms)
Own Rent Anyone smoke in house Y N Who?______________________________

Location City Suburbs Rural Near factories Near water On water
Area is... Normal Odors Damp Near any animals?

Basement Full Slab Crawl space (Full or Part)
Damp Musty Dry Sump pump Dehumidifier Dusty Play area

Heating Hot air Baseboard Steam Electric Radiant Wood/coal burnng Other ______________________________

Air conditioning None Central Room (if room..what rooms)______________________________

Humidification None Central Room Works well? Y N Static electricity in winter? Y N
Window moisture in winter Y N Room humidifier Y N What kind, how often used ______________________________

Air purification None Central Room Please state what kind _______________ What rooms?_______________

Floor (Most) Wood Wall-wall Area Are any rugs damp? Y N Any rugs on slab? Y N

Bedroom

___Cluttered ___Dusty ___Neat What floor is bedroom on? ____________________
Floor covering: Wood Wall-Wall Area rug Other_______________ How old is the rug?_________Kind of padding?__________
Mattress content: ____________________Type of pillows ____________________Type of blankets______________________________
Do you have allergen proof encasings on... Mattress? Pillow? Boxspring ?

Pets

What kind, how many, how long have you had them?______________________________
Do they have the run of the house? Y N Do any of them sleep in bedroom? Y N Explain ______________________________
Is the patient exposed to other animals? ______________________________

LABORATORY TESTS Please give dates and results: A = abnormal N = normal

	CT Sinus	Blood count	Chem profile	Chest x-ray	Other	Other
Pos or Neg						
Date						
Where						

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