

**New Patient History: Page 1 of 7
Questionnaire**

Name: _____

DOB: ___/___/___ Chart #: _____

Welcome to our clinic! Please complete the following information:

Referred by: _____ Primary Provider: _____

Briefly state what symptoms are bringing you here: _____

HAVE OR SUSPECT ALLERGIES, NASAL/SINUS ISSUES

NOTE: If no nasal/sinus issues, check here and go to page 2 (Asthma)

<input type="checkbox"/> sneezing <input type="checkbox"/> itching nose <input type="checkbox"/> nasal congestion/stuffiness <input type="checkbox"/> runny nose • if so: <input type="checkbox"/> mucus clear <input type="checkbox"/> yellow/green <input type="checkbox"/> bloody <input type="checkbox"/> post-nasal drip <input type="checkbox"/> sore throat <input type="checkbox"/> decreased or absent sense of smell <input type="checkbox"/> nose bleeds <input type="checkbox"/> snoring <input type="checkbox"/> bad breath <input type="checkbox"/> nasal polyps <input type="checkbox"/> sinus pressure <input type="checkbox"/> recurrent ear infections <input type="checkbox"/> ear plugging/popping/fullness <input type="checkbox"/> hearing loss <input type="checkbox"/> headache <input type="checkbox"/> eyes itchy <input type="checkbox"/> eyes watery <input type="checkbox"/> eyelids swollen <input type="checkbox"/> history of broken nose <input type="checkbox"/> history of nasal septum deviated <input type="checkbox"/> history of hole in nasal septum	<input type="checkbox"/> previous nasal or sinus surgery • if so, year(s): _____ <input type="checkbox"/> history of sinus infections • if so: <input type="checkbox"/> 1 to 4 per year <input type="checkbox"/> more than 4/yr <input type="checkbox"/> sinus X-Rays done • if so, last one: _____ <input type="checkbox"/> normal <input type="checkbox"/> abnormal <input type="checkbox"/> sinus CT done • if so, last one: _____ <input type="checkbox"/> normal <input type="checkbox"/> abnormal <input type="checkbox"/> ENT physician evaluation • if so, year: _____ by Dr. _____ <input type="checkbox"/> previous allergy skin testing • if so, last one: _____ <input type="checkbox"/> showed allergies <input type="checkbox"/> negative <input type="checkbox"/> previous allergy blood testing <input type="checkbox"/> previous allergy shots • if so, for _____ years stopped in _____ (year) <input type="checkbox"/> still on shots <input type="checkbox"/> helpful <input type="checkbox"/> not helpful	<p>Symptoms are aggravated by:</p> <input type="checkbox"/> tobacco smoke <input type="checkbox"/> exercise <input type="checkbox"/> cold air <input type="checkbox"/> animals <input type="checkbox"/> workplace or school <input type="checkbox"/> dusting or vacuuming <input type="checkbox"/> odors or scents <input type="checkbox"/> yard work <input type="checkbox"/> weather change <input type="checkbox"/> being outdoors <input type="checkbox"/> aspirin / related meds <input type="checkbox"/> other: _____
		<p>Symptoms first began:</p> <input type="checkbox"/> childhood @ age _____ y <input type="checkbox"/> adult @ age _____ y
		<p>Symptoms are worse in:</p> <input type="checkbox"/> spring <input type="checkbox"/> summer <input type="checkbox"/> fall <input type="checkbox"/> winter
		<p>Symptoms interfere with:</p> <input type="checkbox"/> sleep <input type="checkbox"/> work / school <input type="checkbox"/> recreation

Medications (prescription and over-the-counter) that have been tried for allergies:

(ex: antihistamines, nasal sprays, eye drops, etc.)

	Past	Current	Helpful?		
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no

Staff Initials _____ Provider _____ (all items marked above have been reviewed)

Date of visit: ___/___/___

**New Patient History: Page 3 of 7
Questionnaire**

Name: _____
DOB: ___/___/___ **Chart #:** _____

HAVE OR SUSPECT ALLERGY-RELATED SKIN PROBLEMS (Hives, Eczema, etc.)

NOTE: If no skin problems, check here and turn over to page 4

itching
 excessively dry, scaly skin
 recurrent skin infections
 welts, hives
 skin swelling
 other symptoms:

Location of skin problems:

Symptoms first began:
 childhood @ age _____ y
 adult @ age _____ y

Physician diagnosed rash as:

Usual treatments for this rash:
 Medications (see below)
 Moisturizers
 Baths
 Other:

Symptoms are made worse by:

Symptoms interfere with:
 sleep
 work / school
 recreation

Skin is:
 worsening
 unchanged
 improving

Medications (prescription and over-the-counter) that have been tried for skin problems:

	<u>Past</u>	<u>Current</u>	<u>Helpful?</u>		
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> somewhat	<input type="checkbox"/> no

Notes (for office use):

Date of visit: ___/___/___

**New Patient History: Page 5 of 7
Questionnaire**

Name: _____

DOB: ___/___/___ Chart #: _____

Review of Systems

- Eye Disease No Current Past
- Nasal Polyps No Current Past
- Emphysema No Current Past
- Croup No Current Past
- Heart Disease No Current Past
- Mitral Valve Prolapse No Current Past
- Gastroesophageal Reflux No Current Past
- Ulcers No Current Past
- Colitis or Diverticulitis No Current Past
- Bladder Infections No Current Past

- Prostate Problems No Current Past
- Arthritis No Current Past
- Migraines No Current Past
- Seizures No Current Past
- Depression No Current Past
- High Blood Pressure No Current Past
- Diabetes No Current Past
- Thyroid Disease No Current Past

Other: _____

Past Medical History

- Immunizations: Up to date Not up to date
- Flu vaccine in past year: No Yes, last received in _____ (month) of _____ (year)
- Pneumonia vaccine: No Yes, last received in _____ (month) of _____ (year)

Hospitalizations (include year and reason):

Surgeries / Injuries (please circle): Tonsils and Adenoids Gall Bladder Knees Hips Sinuses Heart

Non-allergy medications (prescription and over-the-counter) that you are currently taking:

<u>Medication</u>	<u>Dosage</u>	<u>Reason</u>	<u>Medication</u>	<u>Dosage</u>	<u>Reason</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Notes (for office use):

Date of visit: ___/___/___

**New Patient History: Page 6 of 7
Questionnaire**

Name: _____

DOB: ___/___/___ Chart #: _____

For children under 15, complete the following:

Birth weight: _____

Were there any complications following delivery? yes no

Explain: _____

Has growth and development been normal? yes no

Explain: _____

Immunizations to date? yes no

Notes (for office use):

FAMILY HISTORY (if known)

	Father	Mother	Brothers	Sisters	Children
Hay fever / allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cystic fibrosis (in any relatives): _____

Immune problems (in any relatives): _____

Unexplained symptoms that have not been diagnosed:

Notes (For Office Use):

Staff Initials _____ Provider _____ (all items marked above have been reviewed)

