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Note: You must bring this questionnaire to your appointment.

(If there is a question you do not understand, place a question mark by it in the margin.)

Name _____ DOB _____ Age _____ Date _____

Preferred Pronoun _____

Person completing questionnaire if not the patient _____ Relationship _____

Spring Fall

circle the symptomatic months: Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec year-round symptoms

Check current and/or recent symptoms☑: ***(Please be as complete as possible.)***

ROS:

Eyes: ❑itching ❑burning ❑redness ❑watering ❑swelling ❑shiners (dark circles under eyes) ❑dryness ❑discharge ❑visual problems

ENT:

ears: ❑itching ❑pain ❑infections ❑tubes (year(s)_____) ❑popping ❑hearing loss ❑fullness

nose: ❑itching ❑sneezing ❑congestion (worse in the: ❑AM ❑PM ❑all day) ❑drainage (color_____)
❑postnasal drip ❑snoring ❑runniness ❑sleep apnea ❑blood ❑decreased smell

throat: ❑soreness ❑redness ❑itching ❑mucus ❑throat clearing ❑hoarseness ❑bad breath

Resp: ❑cough (worse in the: ❑AM ❑PM ❑all day, ❑cough wakes patient up at night (# of times waking up_____),
cough is: ❑dry ❑moist (color of discharge_____) ❑cough is worse with exercise,
❑cough is worse with laughter, ❑cough is worse with crying, ❑cough is worse: ❑lying down ❑upright)
❑wheezing year of last chest X-ray_____ results of last chest X-ray_____

CV: ❑tightness in the chest ❑shortness of breath ❑chest pain (location_____)

tobacco: ❑cigarettes (number of packs per day_____ years smoked_____ year quit_____) ❑cigars ❑pipes
❑smokers in the home presently/previously (who_____) ❑smokeless tobacco (chew)
❑electronic cigarette (vapor)

GI tract: ❑heartburn/stomach reflux: worse in the: ❑AM ❑PM ❑after meals ❑all day, ❑heartburn/reflux makes the cough worse
❑hiatal hernia ❑nausea ❑vomiting ❑diarrhea ❑constipation ❑pain (frequency_____)

Const: ❑headache: ❑dull ❑throbbing ❑pressure (❑forehead ❑cheeks ❑between the eyes ❑behind the eyes)
❑temples ❑"band-like" around head ❑back of the head ❑migraines frequency of headaches_____
❑fatigue ❑irritability ❑dizziness ❑night sweats ❑fevers ❑sleeps poorly at night (# of times waking up per night_____)

Skin: ❑eczema ❑rash ❑hives ❑swelling ❑itching ❑dry skin (location_____)

All/Imm: insect reactions to: ❑bees ❑wasps ❑hornets ❑fire ants ❑mosquitoes ❑chiggers
with reactions, was there associated: ❑large local swelling ❑hives ❑wheezing ❑throat swelling ❑nausea/diarrhea
❑unconsciousness ❑emergency treatment required age at time of reaction_____
❑facial rash ❑mouth ulcers ❑easy bruisability ❑dry eyes ❑severe sun sensitivity

Mus/Skel: ❑joint pain ❑joint swelling ❑muscle pains ❑muscle weakness ❑muscle wasting ❑leg swelling

Endo: ❑unintentional weight loss ❑weight gain ❑hot flashes ❑goiter ❑excessive hair loss
❑nursing ❑pregnant ❑planning pregnancy; when_____

Gen/Urin: ❑blood in the urine ❑foamy urine ❑painful urination ❑incontinence ❑bedwetting
(all others negative)

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Patient Name: _____ **DOB** _____

Past Medical History: **(If patient is a child, please complete birth information below)**

birth weight_____lbs. _____oz. ❑pregnancy complications ❑delivery complications

❑vaginal delivery ❑C-section ❑premature ❑full term

❑breast fed (how long?_____) ❑formula fed (❑milk ❑soy) ❑colic ❑feeding problems

❑recurring infections (❑ear ❑sinus ❑tonsil ❑throat ❑chest ❑skin)

❑school problems_____

(All patients should answer the following questions):

immunizations: ❑unknown ❑DTP (year of last tetanus immunization_____) ❑IPV (polio) ❑MMR (mumps measles rubella)

❑HIB (Haemophilus influenza B) ❑hepatitis vaccine ❑HPV

❑ Pneumovax 23 (year _____) ❑ Prevnar 20 (year _____) ❑Prevnar 13 (year _____)

❑flu vaccine (year of last shot_____) ❑reactions:_____

❑ Covid-19 Vaccine Manufacturer _____ Date (s): _____

Medical History: **Surgical History:** **Present Medications:** (including over-the-counter and supplement medications)

list major illnesses or diseases	year	procedure	list names of medications	dosage	# times per day
1)	1)_____	tonsillectomy & adenoidectomy	1)		
2)	2)		2)		
3)	3)		3)		
4)	4)		4)		
5)	5)		5)		
6)	6)		6)		

Please list any recent **antibiotics** prescribed in the past year (for respiratory issues)

list names of medications	dates	dosage	# times per day
1)			
2)			
3)			

7) Covid-19 Vaccine Dose

8)

9)

hospitalizations:

Family History: marital status: (marital status of the parent if the patient is under 18) M S D W Sep

If patient is an adult:

	age	name
Patient's children:	1)	
	2)	
	3)	
	4)	
	5)	

For all patients:

	age	name
Please list patient's brothers and/or sisters:	1)	
	2)	
	3)	
	4)	
	5)	

check illnesses present in immediate family members (blood relatives) ☑:

❑asthma ❑hay fever or nasal allergy ❑eczema ❑hives ❑food allergy ❑insect allergy ❑medication allergy

List Family Member: _____

(Draw arrows to family members with illnesses checked.)

❑lung disease ❑heart disease ❑diabetes ❑cancer (type:_____) ❑immune disorder

❑other _____

Patient Name: _____ **DOB** _____

Environmental History:

home: ❑townhouse ❑apt ❑house (age_____yrs, occupied by patient_____yrs) ❑city/suburb ❑country/farm
❑basement is: ❑dry ❑damp ❑musty ❑poured concrete ❑rock/stone ❑concrete block
❑basement is finished ❑dehumidifier is used in basement ❑crawl space ❑slab

windows: windows open during the ❑spring ❑summer ❑fall ❑never

attic fan: the attic fan is used in the: ❑spring ❑summer ❑fall ❑never used ❑attic fan use makes symptoms **worse**

heating: ❑natural gas (❑forced air) ❑electric ❑wood ❑LP gas ❑oil

humidifier: ❑attached on furnace ❑free-standing (location_____)

air conditioning: ❑central ❑window units (❑window unit in patient's bedroom) ❑air conditioning makes symptoms **better**

air filter: ❑disposable (how often is it changed?_____) ❑HEPA filter ❑electronic ❑electrostatic

bedroom: location (❑above ground ❑basement) ❑wall-to-wall carpeting ❑hardwood floor ❑area rug

pillow: ❑feather ❑synthetic/foam (**number of pillows**_____, **how old**_____yrs) ❑**special** allergy proof covers over pillows
spouse's pillow: ❑feather ❑synthetic/foam (number of pillows_____, how old_____yrs.)

mattress: ❑inner spring mattress (**age of mattress?**_____yrs) ❑foam Tempurpedic (**age of mattress?**_____yrs)
❑sleep number bed ❑**special** allergy proof cover over mattress (zippered type) ❑plastic cover on mattress ❑futon

mattress pad: what temperature water is the mattress pad washed in?: ❑hot ❑warm ❑cold)
❑cotton (washed how often_____ ❑feather mattress pad ❑egg-crate mattress pad

sheets: washed how often_____, what temperature water are the sheets washed in?: ❑hot ❑warm ❑cold

bed cover: ❑comforter (❑feather fill ❑synthetic/fiber fill ❑cotton) ❑blanket ❑quilt ❑bedspread

pets: ❑cats (number_____ ❑indoor ❑outdoor), ❑dogs (number_____ ❑indoor ❑outdoor), ❑other pets_____
Where do the pets sleep at night? _____ Do the pets get ❑ into bedroom ❑on bed

Diet: How many days per week, do you/patient eat: ❑chocolate ___/ 7 days ❑peppermint ___/ 7 days ❑fatty foods ___/ 7 days ❑spicy foods ___/ 7 days ❑tomato products ___/ 7 days ❑citrus juice___/ 7 days?
❑Do you/patient eat 2-3 hours before bed? ❑ drink water or fluid 30 min before bed? **If so, how much?___oz.** ❑water at bedside?

Social History:

alcohol: ❑beer ❑wine ❑liquor (drinks per week_____) tobacco: see HPI illicit drug use: _____

caffeine: ❑tea (cups per day___ ❑caf ❑decaf) ❑coffee (cups per day___ ❑caf ❑decaf) ❑soda (# per day___ ❑caf ❑caffeine free)
❑energy drinks (# per day___)

Occupation (***or*** school & grade if a student): patient_____ spouse_____
(if infant/child: mother's occupation_____ father's occupation_____**)**
daycare/preschool: where_____ daycare hours_____ number of children present_____

hobbies/crafts: _____

Clinical Disagreements: (Please check the items that make you/the patient's symptoms worse☑)

Nasal/sinus symptoms are ***worsened*** by: ❑smoke ❑aerosols ❑dust ❑perfumes ❑basements ❑cats ❑dogs ❑cold air ❑wind
❑beer ❑wine(❑red ❑white) ❑rain ❑humidity ❑temperature changes ❑season changes ❑weather changes ❑other_____

Lung symptoms are ***worsened*** by: ❑smoke ❑aerosols ❑dust ❑perfumes ❑basements ❑cats ❑dogs ❑cold air ❑wind
❑beer ❑wine(❑red ❑white) ❑rain ❑humidity ❑temperature changes ❑season changes ❑weather changes
❑exercise ❑respiratory infections ❑laughing ❑crying ❑aspirin products ❑salad bars ❑heartburn/reflux ❑other_____

Skin symptoms are ***worsened*** by: ❑poison ivy/oak/sumac ❑cut grass ❑leaves ❑plants ❑cosmetics
❑soaps ❑wool ❑others_____

List food and reaction(s):_____

Patient Name: _____ **DOB** _____

Drug Disagreements or Reactions: (Please list **all** reactions.)

	Year	Medication	Reaction
1)			
2)			
3)			
4)			
5)			
6)			

Please list brand names of products the patient uses:

soap_____ shampoo_____ conditioner_____

detergent_____ dryer sheets / fabric softener_____ toothpaste_____

hairspray_____ cosmetics_____

hair gel_____ perfumes or colognes _____ moisturizer_____

Skin History: (Fill out only if experiencing skin problems)

Hives *and/or* rash and/or swelling/angioedema:

features: date of onset _____ worse in: ❑AM ❑PM ❑all day ❑after meals
❑itching present affected areas: ❑arms ❑hands ❑legs ❑feet ❑stomach ❑back ❑head/face
appearance: ❑red ❑flat ❑raised ❑blistery ❑leaves marks/bruises ❑hives/rash move around
❑hives/rash stay in one spot how long do the hives/rash last?_____
hives or rash is described as ❑mild ❑moderate ❑severe

triggers: ❑heat ❑exercise ❑sunlight ❑cold ❑water ❑pressure ❑vibration ❑rubbing/scratching
❑contact (what material/plant/food/animal/cosmetic? _____)
❑menstrual cycle/hormones ❑stress ❑food (which ones?_____)
❑infections/colds/flu ❑medication (which one? _____)

symptoms: ❑recent cold or flu ❑joint pains ❑joint swelling ❑sun sensitivity ❑facial rash ❑fever ❑foamy urine
❑blood in the urine ❑hair loss ❑abdominal pain ❑fatigue ❑mouth sores ❑facial/sinus pain or pressure
❑nasal congestion ❑postnasal drip ❑sinus pressure/headache ❑tooth pain
❑weight gain ❑weight loss ❑goiter ❑diarrhea ❑shakiness ❑hot flashes

new medications (prescription or over-the-counter)_____

_____

new foods_____