INTERNAL USE ONLY
Patient Name ______________________
Chart/Account # ______________ DOB __________
Doctor ______________________
Date ______________________

PATIENT QUESTIONNAIRE

Name ______________________ Date ______________________

Clinic Number ______________________

What problem brings you to the Doctor? ______________________

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Were you referred to us? If yes, by whom? ______________ Primary Physician ______________

Do you want a report sent to your physician? ☐ Yes ☐ No
Describe any problems with:

Nose: (Plugged, itch, sneeze, drainage) ______________________

Eyes: (Water, Itch) ______________________

Ears: ______________________

Sinuses: ______________________

Lungs: (Cough, Wheeze, Shortness of Breath, Tight Chest) ______________________

Skin: ______________________

Frequent Infections: ______________________

When did your problem start? ______________________

When do you have problems? ☐ Spring ☐ Summer ☐ Fall ☐ Winter

What have you found triggers your problem? (Dust, animals, smells, exercise, etc.) ______________________

____

What are you currently using? (List ALL Medications) ______________________

____

What tests have been done? (X-Rays, Allergy Tests, Breathing Tests, Etc.) ______________________

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PLEASE COMPLETE BOTH SIDES OF FORM PRIOR TO YOUR APPOINTMENT

List you medication allergies. ______________________________

____

List your food allergies. ______________________________

____

Any allergy to wasps, bees, yellow jackets, hornets? ______________________________

Do you smoke? ______________ Did you ever smoke? ______________

Does anyone smoke at home? ______________ Who? ______________

What types of pets do you have? ______________________________

Type of pillows-Feather, Non-feather Type of Heat ______________________________

What is your Job? ______________________________

What are Your Hobbies? ______________________________

Family History: Anyone with Hayfever, Asthma, Eczema (Atopic Dermatitis), Immunodeficiency or Cystic Fibrosis? (List)

____

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Other: ______________________________

List past Hospitalizations and Surgeries: ______________________________

Do you have other medical problems currently? ______________________________

Check any current or past areas with medical problems:

☐ Eyes	☐ Nose	☐ Ears	☐ Skin
☐ Hair	☐ Throat	☐ Chest	☐ Heart
☐ Stomach	☐ Gall Bladder	☐ Bowels	☐ Liver / Hepatitis
☐ Nerves	☐ Bladder / Kidney	☐ Legs	☐ Blood Vessels
☐ Thyroid	☐ Pneumonia	☐ Asthma	☐ Hives
☐ Anaphylaxis	☐ Arthritis	☐ Immune System	☐ Headache
☐ Hypertension	☐ Depression	☐ Anxiety	☐ Cholesterol
☐ Weight Loss	☐ Fever	☐ Other ______________	

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