



INTERNAL USE ONLY

Patient Name _____
Chart/Account # _____ DOB _____
Doctor _____
Date _____

PATIENT QUESTIONNAIRE

Name _____ Date _____

Clinic Number _____

What problem brings you to the Doctor? _____

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.) _____

PLEASE COMPLETE BOTH SIDES OF FORM PRIOR TO YOUR APPOINTMENT

605-336-6385 Fax 605-336-6513

2200 West 49th Street, Suite 104, Sioux Falls, SD 57105 dakotaallergy.com

Mark E. Bubak, MD | Brian A. Brennan, MD | Lindsey R. Peterson, CNP



List your 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)

Other: _____

List past Hospitalizations and Surgeries: _____

Do you have other medical problems currently? _____

Check any current or past areas with medical problems:

- | | | | |
|---------------------------------------|-------------------------------------------|----------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Nose | <input type="checkbox"/> Ears | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Hair | <input type="checkbox"/> Throat | <input type="checkbox"/> Chest | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Bowels | <input type="checkbox"/> Liver / Hepatitis |
| <input type="checkbox"/> Nerves | <input type="checkbox"/> Bladder / Kidney | <input type="checkbox"/> Legs | <input type="checkbox"/> Blood Vessels |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Immune System | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Fever | <input type="checkbox"/> Other _____ | |

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