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 | Lindsey R. Peterson, CNP

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)

____

____

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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