New Patient Questionnaire

PATIENT NAME: _____ **DATE OF BIRTH:**_____ **TODAY'S DATE:** _____

BRIEFLY DESCRIBE REASON FOR THIS VISIT:

_____

_____

_____

_____

_____

_____

CHECK (✓) THE SYMPTOMS YOU HAVE OR HAVE HAD:

Nasal Symptoms

- ❑ Frequent Sneezing
- ❑ Runny nose
- ❑ Nasal congestion
- ❑ Nasal itching
- ❑ Frequent nose bleeds
- ❑ Loss of smell
- ❑ Nasal polyps

Sinus

- ❑ Frequent infections
- ❑ Pressure in cheeks
- ❑ Pressure around eyes
- ❑ Drainage down back of throat

Eyes

- ❑ Itching
- ❑ Burning
- ❑ Redness
- ❑ Swelling of eyelids

Ears

- ❑ Pain
- ❑ Itching
- ❑ Plugging
- ❑ Loss of hearing
- ❑ Frequent Infections

Lungs

- ❑ **Asthma**
- ❑ **Wheezing**
  - ❑ Mild
  - ❑ Moderate
  - ❑ Severe
- ❑ **Coughing**
  - ❑ All the time
  - ❑ Mostly at night
  - ❑ Mostly during day
  - ❑ Productive of sputum
  - ❑ Dry cough
- ❑ **Wheezing or coughing worse with exercise**

Gastrointestinal

- ❑ Frequent episodes of vomiting, diarrhea or abdominal cramping

Food Allergy

- ❑ Hives or skin rash after eating
- ❑ Heartburn or Reflux
  List which foods

Skin

- ❑ Contact rash
- ❑ Eczema
- ❑ Hives
- ❑ Itching

Headaches

Type of Headaches:

- ❑ Sinus
- ❑ Migraine
- ❑ Tension
- ❑ Associated with menses

Location of headaches:

- ❑ Frontal
- ❑ Temple area
- ❑ Back of head

Frequency of headaches:

- ❑ Daily
- ❑ Occasionally
- ❑ Seldom

Please continue on reverse side.

Dr. Notes: _____

_____

_____

_____

PATIENT NAME: _____ DATE OF BIRTH: _____

ARE YOUR SYMPTOMS WORSE:

- ❑ At home
- ❑ At work
- ❑ Out of doors
- ❑ In the morning
- ❑ At night-time
- ❑ In the afternoon
- ❑ In the winter
- ❑ In the spring
- ❑ In the summer
- ❑ In the fall
- ❑ Around insect spray
- ❑ Around chemicals/smoke
- ❑ Around paint
- ❑ During rain
- ❑ In high humidity
- ❑ In dry weather
- ❑ In cold weather

ENVIRONMENT: Where were you born and raised:? _____

How many years have you lived in your current hometown? _____ In your present home: _____ How old is your home: _____

Is your home in [ ] Country [ ] Town What is your occupation? _____

Are you exposed to anything unusual at Work?	☐ Yes ☐ No	Does anyone smoke indoors?	☐ Yes ☐ No
Do you have pets? ☐ Dog ☐ Cat ☐ Birds		Do you have carpets in the bedroom?	☐ Yes ☐ No
Are the pets ever indoor?	☐ Yes ☐ No	Do you have a standard mattress?	☐ Yes ☐ No
Do the pets sleep in the bedroom?	☐ Yes ☐ No	Do you sleep on a feather pillow?	☐ Yes ☐ No
Do pets cause increased symptoms?	☐ Yes ☐ No	Do you have upholstered furniture in bedroom?	☐ Yes ☐ No
Do you have central heat/air-conditioning?	☐ Yes ☐ No		

MEDICAL HISTORY:

Who is your Primary Care Doctor? _____		Have you had a chest or sinus x-ray? If yes give approximate date of last x-ray:	☐ Yes ☐ No
Do you sleep well?	☐ Yes ☐ No	Do you smoke? If yes How many years: How many per day?	☐ Yes ☐ No
Is your appetite good?	☐ Yes ☐ No	Have you smoked in the past? How long: When did you quit:	☐ Yes ☐ No
Have you ever seen and ear, nose, and throat (ENT) doctor?	☐ Yes ☐ No	Does aspirin cause any allergy symptoms?	☐ Yes ☐ No
Have you had a tonsillectomy, adenoidectomy?	☐ Yes ☐ No	Have you ever had a serious reaction to an insect sting? If so, which insect:	☐ Yes ☐ No
Have you had surgery or an injury to the nose?	☐ Yes ☐ No	Do you engage in regular physical exercise?	☐ Yes ☐ No
Have you had any other surgery? If yes specify:	☐ Yes ☐ No	Have you had previous allergy tests and treatment? If so, when:	☐ Yes ☐ No

MEDICATION INFORMATION: If you are **ALLERGIC** to any medications please list them below:

_____ _____ _____ _____

What medications do you now take regularly for any reason: ⇩

_____ _____ _____ _____

What medications have you tried for allergy symptoms in the past: ⇩

_____ _____ _____ _____

Dr. Notes: _____

_____

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_____

PATIENT NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS - Check the symptoms or diseases you now have or have had:

❑ Ankles swelling	❑ Dizzy spells	❑ High blood pressure	❑ Unable to tolerate heat or cold
❑ Cancer	❑ Fainting spells	❑ Pain in bones or joints	❑ Sudden weight change
❑ Cataracts	❑ Glaucoma	❑ Pneumonia	❑ Swelling in the neck
❑ Chest pain	❑ Heart pain	❑ Kidney or bladder problems	❑ Thyroid problems
❑ Diabetes	❑ Heart problems	❑ Shortness of breath	❑ Unusual muscular pain

IMMUNIZATIONS	***Illness***	***Immuni-zation***
Chicken Pox	☐ Yes	☐ Yes
German measles	☐ Yes	☐ Yes
Influenza	☐ Yes	☐ Yes
Measles	☐ Yes	☐ Yes
Mumps	☐ Yes	☐ Yes
Pneumonia	☐ Yes	☐ Yes
Polio	☐ Yes	☐ Yes
Tetanus	☐ Yes	☐ Yes

FAMILY HISTORY	Father	Mother	Brother	Sister	Children	Grand Parent
Asthma	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐
Food allergy	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐
Hi-Blood Pressure	☐	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐	☐
Insect Allergy	☐	☐	☐	☐	☐	☐
Migraine Headache	☐	☐	☐	☐	☐	☐

Other family members that come to this clinic: _____

_____

_____

_____

Dr. Notes: _____

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_____

Physical Examination: Wt. _____ Ht. _____ Temp. _____ BP _____ Age _____

General:

Face: Frontal _____ Maxillary _____ sinus tenderness suborbital edema ("Allergic Shiners") _____

Eyes: Conjunctiva: injected _____ Fundi normal _____

Nose: Septum deviated _____ Mucous membranes: Edematous _____ pale _____ dusky _____ red _____ polyps _____
pink _____ fraible _____ hyperemic _____ clear _____ normal _____ WNL _____

Drums: Retracted _____ fluid _____ inflamed _____ normal _____ dull _____ WNL _____ Tubes _____

Throat: Increased lymphoid tissue _____ PND seen _____ normal _____ injected _____ WNL _____

Tonsils: Moderate _____ large _____ erythematous _____ exudate present _____ absent _____ small _____ not enlarged _____

Neck: Glands _____ trachea midline _____ thyroid _____

Chest: Diaphragms move normally _____ Shape _____

Lungs: Clear _____ insp. wheezes _____ exp. wheeze _____

Rales: _____ decreased breath sounds _____

Rhonchi: _____ Wheeze/Rhonchi on forced expiration only _____

Heart: Normal size, rhythm and sound _____

Abdomen: normal _____ no significant abnormality _____

Extremities: Pulse present _____ edema _____ cyanosis _____

Lymph nodes: normal _____ or _____

Skin: Normal _____ Clear _____ Hives _____ Rash _____

- ❑ Acute upper respiratory infection
- ❑ Allergic dermatitis (Atopic eczema)
- ❑ Allergic rhinitis seasonal
- ❑ Allergic rhinitis, perennially
- ❑ Anaphylaxis
- ❑ Angiodema
- ❑ Animal Dander
- ❑ Asthmatic bronchitis
- ❑ Asthma, bronchial
- ❑ Asthma, bronchial, seasonal
- ❑ Asthma, exercised-induce
- ❑ Bronchitis, acute
- ❑ Bronchitis, chronic
- ❑ Chronic obstructive pul. disease
- ❑ Contact dermatitis
- ❑ Drug allergy
- ❑ Food allergy
- ❑ Headaches
- ❑ Hyperactivity
- ❑ Insect allergy
- ❑ Nasal polyps
- ❑ Ophthalmic allergy (Conjunctivitis, allergic)
- ❑ Pharyngitis, acute
- ❑ Rhinitis, medicamentosa
- ❑ Serous otitis media
- ❑ Sinusitis, acute
- ❑ Sinusitis, chronic
- ❑ Urticaria, acute
- ❑ Urticaria, chronic
- ❑ Vasomotor rhinitis

Other Diagnoses: _____ _____ _____ _____

Treatment Plan:

Dictation: Yes _____ Date _____ No _____

Return visit: _____ days _____ weeks _____ months _____

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