We realize this form is long but filling it out completely will help us to diagnose and treat your condition. Thanks in advance.

PATIENT QUESTIONNAIRE

Date of 1st visit ______

Last | First | Middle | Age | Occupation | Brithdate

Address | Home Tel. | Work Tel.

Mother' Name (Adults omit) | Age | Occupation | Who referred you?

Father' Name (Adults omit) | Age | Occupation | Primary Care Doctor

1. How may we help you? Please list main complaints, starting with the one that concerns you the most.	Age of onset
A.	
B.	
C.	

2. START AT THE BEGINNING AND DESCRIBE YOUR ILLNESS. Please give as many details as you can.

3. ARE YOUR SYMPTOMS **Present all year?** Yes No **How often?** Daily Most of the time Half Occasionally

Worse during certain months? Yes No **Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec**

4. WHAT MAKES SYMPTOMS WORSE? (Circle)

			Infection	Dog
Food	Drafts	Raking leaves	Often indoors	Cat
Drugs	High humidity	Barns	Mostly outdoors	Other animals
Aspirin	Dampness	Fatigue	Occupation	Cutting the grass
Cosmetics	Cold air	Exercise	School	Air Conditioning
Perfumes	Weather changes	Stress / Emotion	Rubber	Windy days
Odors	Basements	Menstrual period	Laughter	Winter
Alcoholic beverages	Musty odors	Mornings	Visits to homes	Spring
Cigarette smoke	Dust or Dusting	Nighttime		Summer
OTHER:				Fall

5. WHAT IMPROVES SYMPTOMS?

Medication	Daytime
Winter	Nighttime
Spring	Allergy injections
Summer	Away from home
Fall	Vacations
Rest	Air Conditioning
Other:	

6. MEDICATIONS: List **ALL** medications you are *now* on for whatever reason. Include past Rx that you were given for your problem. **If answer is Yes, Please √**	Helped?	Taken always?	On now?	Side effects? Describe

Ever on allergy shots? Yes No When and how long Help? Yes No Any major reactions? Yes No

System Review

Do you now have or have you ever had....Circle items that you have now and underline those that you had at one time and do not have now

How is your general health? Excellent Fair Poor

Fainting Spells | Always tired | Eat lots of junk food
Bruise easily | General weakness | Frequent aches & pains
Chills/fever | Change in weight | Change in appetite
Eat a balanced diet | Always thirsty

Head Symptoms

Absent Present How long?

1. Nose

Head colds how many in past year

Frequent sneezing | Poor sense of smell | "Fullness" of sinuses
Runny, drippy nose | Yellow/green discharge | Nose bleeds
Stuffy nose | Sinus headaches | Dry nose
Itchy nose | Pressure when bending | Funny taste in mouth

2. Ears

Hearing loss | Pain | Congestion
Popping | Ringing | Frequent ear infections
Plugging | Fullness | Itchy
Drainage What color

3. Eyes

Watery | Itchy | Burning
Eyelid Puffiness | Redness | Blurred vision
Double vision | Change in vision | Dryness
Painful

4. Throat

Drip in back of throat...Thick? Thin? Colored at times?

Clearing of throat | Cough from drip? | Tooth pain
Itch at roof of mouth | Bad breath | Difficulty swallowing
Hoarseness | Poor sense taste | Glands swollen
Tickle back of throat | Frequent sore throats

5. Do you use nose sprays or drops? Yes No
If Yes What name(s)

6. Do you take blood pressure pills? Yes No

7. Ever treated for Sinus infections Nasal polyps

8. Last sinus x-ray: Positive Negative

Lungs

Shortness of breath | Wheezing | Heaviness in chest
Tightness in chest | Night cough

Coughing/wheezing... ____ After exercise____ After laughter/stress
____ When lying down at night
____ Nighttime awakenings due to cough/wheeze
____ How many times per night?
____ How many nights per week?

Cough is? Dry Loose Bring up sputum
Sputum production (Color________________)
Night sweats | Cough up blood

Heart

Murmur | Irregular pulse | Large veins in legs
Palpitations | Pillows needed to sleep?______
Swollen ankles | Chest discomfort w exercise

Abdomen

Jaundice | Constipation | Nausea
Vomiting | Diarrhea | Distension
Frequent belching | Heartburn | Acid taste in mouth
Indigestion | Bowel habit change | Abdominal cramping
Rectal pain w bowel movement
Changes in ...Bowel habits ___Color of stool

Extremities

Swelling of legs | Joint swelling/Pain | Discoloration
Cold hands/feet | Blue/purple hands

Genito-Urinary tract

Pain/burning on urinating
Discolored urination | Bed wetting
Other____________________

Women

GYN problems | Pain on menstruation | Breast discharge
Lump in breast | Bleeding between periods

Age of menses___ | Menses every_____days
Lasts for ____days | Menopause began____ended ____

Deliveries | Miscarriages
Birth control method# of pregnancies

Men

Difficulty w erection | Weak urine stream | Prostate problems

Neurological

Frequent headaches | Convulsions | Fainting
Dizziness | Anxiety | Lightheadedness
Room seems spinning | Mood swings | Balance problems
Loss of consciousness | Leg or arm weakness | Muscle spasms
Muscle strength loss | Visit mental health professional
Tingling of extremities | Uncontrollable tension
Change in sensation of hands or feet

Glandular

Constant thirst | Very sluggish
Excessively nervous | Change in hair or skin texture
Excessive getting up at night to go to urinate
Always seem ___cold ___hot when everybody else is comfortable

Skin

Hives | Itchiness | Rashes
Dryness | Easy bruising | Poison Ivy
Insect bite severe | Insect sting reactions | Skin infections

Do you have a food intolerance? Explain ______

Have you seen any other doctors recently for current or related reasons?

Name	Date	Reason