

New Patient Questionnaire

Patient Name: _____
Date of Birth: _____ Male _____ Female _____
Address: _____
Home Phone: _____ Work: _____
Date: _____



PATIENT'S PRIMARY PHYSICIAN: _____

PHYSICIAN'S ADDRESS: _____

OTHER PHYSICIANS INVOLVED IN THE PATIENT'S CARE _____

WHAT IS THE MAIN REASON FOR THE APPOINTMENT: (Please describe)

Other bothersome symptoms: _____

Have you noticed anything that makes this problem better? _____

Have you noticed anything that makes this problem worse? _____

MEDICATIONS: (Please bring ALL medications to the appointment)

List all current medications (including ointments, creams, non-prescription drugs, and nose sprays)

CIRCLE/LIST ANY MEDICAL DIAGNOSES: Hypertension High-cholesterol Diabetes Hyper/Hypo-thyroid Reflux
Asthma Eczema Food Allergy Others: _____

ALLERGIES TO MEDICATIONS: _____

ENVIRONMENT:

Please Circle conditions that apply to the home: House Apartment Mobile Home Farm
What year was the home built? _____ Does the home have mold or water damage? ___Yes ___No

Please Circle items found in the Patient's bedroom: Carpeting Hardwood/Laminate flooring Stuffed toys
Dust covers on mattress/pillows HEPA Filter Feather Pillows Down Comforter

Please Circle or Check:

Does the home have: A/C (Central Window) Humidifier Dehumidifier Air Cleaner Swamp Cooler?
Does the home have pets? Dog Cat Bird Hamster No Pets Other: _____
Do any family members smoke? ___Yes ___No; If yes, who smokes? _____
Does the Patient smoke? ___Yes ___No; If yes, how many packs a day? _____
Has the Patient ever smoked? ___Yes ___No; If yes, how many years did the Patient smoke? _____
Recreational drug use? ___Yes ___No Alcohol intake: never occasionally frequently daily

SOCIAL HISTORY:

Who lives at home? _____

Patient's occupation (if applicable) _____

If in school, name of school _____ Grade in school _____

Describe work or school environment: _____

Attends day-care (if applicable) ___Yes ___No

DIET:

Are foods suspected to cause symptoms? ___Yes ___No

Describe any reactions to foods: _____

Currently on special diet? ___Yes ___No Describe: _____

PAST MEDICAL HISTORY:

Has the patient ever seen an Allergy doctor? ___Yes ___No

Name of Allergy doctor, city, and year seen: _____

Has the Patient ever been on allergy shots? ___Yes ___No If yes, for how many years? _____

Insect sting reactions: (Please describe) _____

Immunizations up to date? ___Yes ___No Describe any reactions: _____

List previous surgeries: _____

Previous injuries to nose? ___Yes ___No

DOES THE PATIENT HAVE ANY OF THE FOLLOWING?

Please Circle (Yes) or (No) for each question:

Chronic fever	Yes No	Bloating	Yes No	Chronic joint swelling	Yes No
Recent chills	Yes No	Daily vomiting	Yes No	Muscle atrophy/wasting	Yes No
Unexpected weight loss	Yes No	Chronic diarrhea	Yes No	Skin boils/abscess/psoriasis	Yes No
Loud snoring	Yes No	Heartburn/Reflux	Yes No	Seizures/Tremors	Yes No
Sleep apnea	Yes No	Constipation	Yes No	Migraine headaches	Yes No
Hearing problems	Yes No	Blood in vomit	Yes No	Mental health diagnosis	Yes No
Chest wall deformity	Yes No	Painful urination	Yes No	Reactions to Latex	Yes No
Coughing up blood	Yes No	Blood in urine	Yes No	Family History of Asthma	Yes No
Chronic chest pain	Yes No	Recurrent urinary tract infections	Yes No	Family History of Nasal Allergies	Yes No
Heart palpitations	Yes No	Thyroid disease	Yes No	Family History of Immune Deficiency	Yes No
Heart arrhythmia	Yes No	Diabetes	Yes No	Family History of Eczema	Yes No
Daily abdominal pain	Yes No	Chronic joint pain	Yes No	Family History of Swelling	Yes No

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