SHORELINE ALLERGY & ASTHMA ASSOCIATES, LLP

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PATIENT QUESTIONNAIRE

Name: First:_____ **MI**_____ **Last:**_____

Date of Birth (MM/DD/YY):_____/_____/_____

After completing the above information, please complete ALL sections below to the best of your ability.

A. Chief Complaint: Why are you seeing the doctor? (rash, cough, wheezing, congestion, runny nose, hives, allergic reaction, etc.)

_____
_____
_____
_____

B. What seems to make your symptoms worse (circle)?

dust trees grass weeds mold feathers exercise cold air smoke stress weather changes strong odors menstruation respiratory infections Other:

animals (list)_____
foods (list)_____

C. When are your symptoms worse?

Jan Feb March Apr May June July Aug Sept Oct Nov Dec Year-Round

I don't know N/A

Time of day?_____

D. Do you have a history of allergies or reactions to the following (circle):

Bee/other insect Aspirin or other NSAIDs
Latex Local Anesthetics
Pollen/Dust/Dander Other (list)

E. Past Medical History, Current Conditions or Illnesses (e.g. diabetes, thyroid, high blood pressure, pneumonia etc.):_____
_____
_____
_____
_____

G. Surgical History (type and approximate dates):

_____
_____
_____
_____
_____
_____
_____

F. Family History: Please indicate the relatives who have allergic diseases (list the types: asthma, hay fever, eczema, hives, drug, insect sting, food, etc).

Mother:_____
Father:_____
Brother(s):_____
Sister(s):_____
Children:_____

(CONTINUE ON BACK PAGE)

H: Social History:

Occupation/Grade:_____ **N/A**

Daycare? **Yes** **No** **N/A**

Pets:_____ **none**

Significant occupational/environmental exposures?_____

Do any smokers live in the household? Yes No

If patient age >13 years. Please answer:

Have you smoked? **Yes** **No** If yes, start date:_____

Still smoking? **Yes** **No** If no, quit date:_____

How many packs a day?_____

I. Medication Allergies:
(Approximate date and reaction)

_____

_____

_____

J. Medications: List all *currently* prescribed medications and over-the-counter medications you are taking:

Name Dose Frequency Date started

Patient name (print name)_____

Guardian (name/relation)_____

Patient/Guardian Signature:_____date:_____

****PLEASE DO NOT WRITE BELOW THIS LINE - FOR PHYSICIAN USE ONLY****

Sections A-J reviewed and additional notes documented by:

Physician Signature_____Date _____

Intake/visit form