



BRIEFLY DESCRIBE THE REASON FOR THIS VISIT (what is your main concern or symptom?):

CHECK SYMPTOMS YOU HAVE OR HAVE HAD:

Nasal Symptoms Past Present

- Nasal congestion
- Runny nose
- Nasal discharge
- Postnasal drip
- Snoring
- Nasal itching
- Frequent sneezing
- Frequent nose bleeds
- Nasal polyps
- Loss of sense of smell
- Loss of sense of taste

Sinus Past Present

- Frequent infections
 - Pressure in sinuses
 - Postnasal drip
 - Nighttime cough
 - Sinus headaches
 - Bad breath
- How many times in the last year have you taken an antibiotic for a sinus infection? _____
- Is so, when was the last time? _____
- Have you ever had a sinus CT (CAT scan) or x-rays? No Yes
- If yes, when was most recent one? _____
- Have you ever had sinus surgery? No Yes. If yes, date: _____

Eye Symptoms Past Present

- Itching
- Watery eyes
- Redness or burning
- Swelling of eyelids

Frequent Ear Infections

- Past Present
- Have you had pressure equalization tubes? No Yes
- If yes, date(s): _____

Ear Symptoms Past Present

- Pain Itching
- Pressure Loss of hearing

Headaches Past Present

- Sinus Migraine
- Tension With menses

Location of headaches

- Frontal Back of head
- Temple area One-sided

Is your headache

- Sharp pain Dull pain
- Throbbing pain

- When you have headaches,
- do you have nausea or vomiting?
 - do you have difficulty with vision?
 - are you bothered by light?
 - are you bothered by noise?

Frequency of headaches

- Daily Weekly
- Occasionally Seldom

Effective medicines for headaches (list names): _____

Lung Symptoms Past Present

- Asthma
- Wheezing
- Chest "colds" or congestion
- Chest symptoms with exercise
- Shortness of breath at rest
- Shortness of breath at night
- Sudden attacks of shortness of breath
- Pneumonia
- Bronchitis
- Bronchiolitis
- Croup
- Cough
- Coughing up blood

Gastrointestinal Past Present

- Frequent nausea or vomiting
- Frequent episodes of diarrhea
- Heartburn
- Regurgitation of food
- Acid or sour taste in your mouth in the morning
- Abdominal cramping
- Itching of mouth or throat
- Food allergy: list which foods _____

Skin Symptoms Past Present

- Hives Itching
- Eczema Contact rash

WHICH OF THE FOLLOWING TRIGGER FACTORS MAKE YOUR SYMPTOMS WORSE? (check all that apply)

- Bronchitis
- Colds, influenza
- Sinus infections
- Nonsteroidal antiinflammatory medicines (such as ibuprofen or naproxen)
- Aspirin
- Exercise
- Wines, alcoholic beverages
- Cigarette smoke
- Perfumes, hairsprays, strong odors
- Cold air
- Nighttime
- Weather changes
- Cutting grass
- Cats
- Dogs
- Other animals (specify) _____
- Foods (specify) _____
- Food additives (specify) _____
- Laughter
- Strong emotions or stress
- Menstrual cycles
- Damp, musty places
- House dusting or vacuuming
- Occupational exposures
- Air pollution



ALLERGY HISTORY

Are your symptoms: Year-round Seasonal Year-round with seasonal increases?
 If seasonal, which season(s)? (check all that apply) Spring Summer Fall Winter
 Which months are worse for you? January February March April
 (check all that apply) May June July August
 September October November December

Have you had allergy skin testing? No Yes If yes, by whom? _____

Please list dates and results of these tests: _____

Have you had allergy shots? No Yes

If yes, when did you receive them and for how long? _____

Did allergy shots help your symptoms? No Yes

Please list all known inhalant, food, and medicine allergies other than those detected only by skin testing

WHAT YOU ARE ALLERGIC TO	REACTION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any other allergy problems, such as latex sensitivity or insect sting allergy (bee, wasp, yellow jacket, hornet, or fire ant)?
 No Yes If yes, please describe: _____

USE OF MEDICATIONS

Please list all current ORAL and INHALED medications prescribed by your doctor and any nonprescription medicines you are taking:

MEDICATION & STRENGTH	HOW MUCH & HOW OFTEN	TAKEN DAILY?	MEDICATION & STRENGTH	HOW MUCH & HOW OFTEN	TAKEN DAILY?
_____	_____	YES NO	_____	_____	YES NO
_____	_____	YES NO	_____	_____	YES NO
_____	_____	YES NO	_____	_____	YES NO
_____	_____	YES NO	_____	_____	YES NO
_____	_____	YES NO	_____	_____	YES NO
_____	_____	YES NO	_____	_____	YES NO
_____	_____	YES NO	_____	_____	YES NO

Please list medications you have taken in the past but no longer are taking for the symptoms being evaluated here: _____

PAST MEDICAL HISTORY

List all hospitalizations or **None**

DATES OF HOSPITALIZATION	NAME OF HOSPITAL	REASON FOR HOSPITALIZATION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all surgical procedures and the date they were done or **None**

PROCEDURE	DATE
_____	_____
_____	_____
_____	_____
_____	_____

Have you had any serious accidents? No Yes If yes, please describe _____
 Are your immunizations up to date? No Yes
 Date of last flu vaccination _____ Date of last pneumonia vaccination _____

ASTHMA SEVERITY

Have you been admitted to hospital because of asthma? No Yes. If yes, how many in the last year? _____
 Have you been admitted to an Intensive Care Unit because of asthma? No Yes. If yes, when? _____
 Have your asthma symptoms resulted in respiratory arrest, intubation or use of a mechanical ventilator? No Yes

List any previous testing you have had or **None**

	APPROXIMATE DATE	RESULT
<input type="checkbox"/> Chest x-ray	_____	_____
<input type="checkbox"/> Sinus CT or x-ray	_____	_____
<input type="checkbox"/> Sweat chloride test	_____	_____
<input type="checkbox"/> Pulmonary function tests	_____	_____
<input type="checkbox"/> Barium swallow	_____	_____
<input type="checkbox"/> Nasopharyngoscopy or laryngoscopy	_____	_____
<input type="checkbox"/> Esophagoscopy	_____	_____
<input type="checkbox"/> Bronchoscopy	_____	_____
<input type="checkbox"/> Immunoglobulin studies	_____	_____
<input type="checkbox"/> Other _____	_____	_____

Have you had any of the following or **None**?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Any severe infections |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Gastroesophageal reflux | _____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Positive tuberculin skin test | _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | _____ |

Other significant illnesses _____

REVIEW OF SYSTEMS

Please circle any of the following symptoms that you are currently experiencing or have had or **None**

General	Fever, chills, night sweats, loss of appetite, fatigue, weight loss, weight gain, cold intolerance, heat intolerance, headaches
Eye, Ear, Nose, or Throat	Blurred vision, double vision, eye irritation, eye discharge, vision loss, eye pain, discomfort from bright light, glaucoma Ear pain or discharge, ear infections, ringing in ears, decreased hearing, loss of balance Excessive tearing, dry eyes, itchy eyes, conjunctivitis, eye discharge Nasal congestion, runny nose, nasal discharge, postnasal drainage, nasal itching, frequent sneezing, nosebleeds, loss of sense of smell, loss of sense of taste, Sinus infections, pressure in sinuses, bad breath Sore throat, hoarseness, trouble swallowing liquids or food
Lymph Nodes (Lymph "Glands")	Swelling, tenderness
Heart	Chest pains, palpitations, fainting, shortness of breath on exertion, inability to lie flat in bed, swelling of hands or ankles
Lungs	Wheezing, chest congestion, chest symptoms with exercise, shortness of breath at rest, breathing problems that wake you from sleep, pneumonia, bronchitis, croup, cough, coughing up blood
Intestinal Tract	Nausea, vomiting, diarrhea, constipation, change in bowel habits, indigestion, abdominal pain, food intolerances, blood in stool
Reproductive	Irregular periods, skipped periods, unusual vaginal bleeding, genital sores, menopause, infertility, miscarriages, impotence or decreased libido, unplanned pregnancy, planned pregnancy
Urinary	Pain when urinating, blood in urine, discharge, frequent urination, trouble starting to urinate, awakening at night to urinate, incontinence, kidney stones, kidney infections, prostate problems
Rheumatologic & Orthopedic	Back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness, arthritis, gout, osteoporosis, fractured bones
Skin	Skin rash, skin tumors or growths, excessive hair loss, severe itching, dryness, abnormal bruising, bleeding
Neurologic & Psychologic	Transient paralysis, numbness, weakness, tingling sensations, seizures, fainting spells, tremors, dizziness, difficulty with memory, inability to concentrate, migraine headaches, anxiety, depression

Please elaborate on any symptoms that are particularly bothersome to you: _____

FAMILY HISTORY

FOR ADULT: Age and gender of your children or **None**: _____

FOR CHILD: Age and gender of child's siblings or **None**: _____

<input type="checkbox"/> None or unknown	Father	Mother	Patient's siblings	Grand-parents	Patient's children	Others
Seasonal nasal symptoms (hayfever)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic nasal symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis (non-smoker)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicine allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any relatives

- With cystic fibrosis? No Yes If yes, who? _____
- Who have had nasal polyps or sinus surgery? No Yes If yes, who? _____
- Who have had allergic reactions to aspirin or ibuprofen? No Yes If yes, who? _____
- Who have had children who died in the first 5 years of life? No Yes If yes, who? _____
- Who have received gammaglobulin shots for frequent infections? No Yes If yes, who? _____

SOCIAL HISTORY

Do you smoke? No Past Present If past or present, when did you started smoking? _____ quit smoking? _____
How many packs per day do you (did you) average? _____

ENVIRONMENTAL HISTORY

How long have you lived in your current hometown? _____ How long have you lived In your present home? _____
 How old is the dwelling in which you live? _____ Do you live in a house, apartment, or trailer? _____
 Check rooms with wall-to-wall carpeting: bedroom living room TV room other _____
 What kind of bed do you sleep on? single bed bunk bed waterbed other _____
 For child, stuffed animals in bedroom Yes No If yes, in bed? Yes No
 Do you have an allergen-proof cover on your mattress? Yes No
 Type of pillow or comforter (check all that apply) foam feather fiberfill other _____
 Do you have an allergen-proof cover on your pillow? Yes No
 How often is the inside of the pillow washed? once a month or more less often than once a month
 What temperature water do you use to wash bedding (blankets and sheets) cold or warm hot
 Do you have any warm-blooded pets? No Yes If yes, check all that apply and give number that you have:
 cat (how many? _____) dog (how many? _____) bird (how many? _____) other _____
 Do any pets stay or come indoors? No Yes If yes, where do the pets sleep? _____
 Does anyone smoke in your home? No Yes

FOR ADULT

Your occupation _____ Your employer _____
 How long in this occupation? _____
 Spouse's occupation _____ Spouse's employer _____
 How long in this occupation? _____

Do you believe that your current or previous occupation has any bearing on your illness? No Yes
If yes, please explain: _____

Have you had any job with high exposure to fumes, chemicals, dust or other noxious substances? No Yes
If yes, please explain: _____

FOR CHILD

Father's occupation _____ Father's employer _____
 How long in this occupation? _____
 Mother's occupation _____ Mother's employer _____
 How long in this occupation? _____

For child, is or was he or she ever in day care? No Past Present
 If Past or Present, at what age did he or she start? _____ Number and ages of children there? _____
 If Past or Present, how often did or does he or she attend daycare? _____
 Is or was the child ever in pre-school? No Past Present
 If Past or Present, at what age did he or she start? _____ Number and ages of children there? _____
 If Past or Present, how often did or does he or she attend preschool? _____
 If in school, current grade: _____
 Are there other children in the home besides siblings? Yes No If yes, give number and ages _____

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT?

WHO IS YOUR PRIMARY CARE DOCTOR?

Name _____ Specialty _____

WHICH DOCTOR REFERRED YOU HERE?

Name _____ Specialty _____

ARE THERE OTHER DOCTORS WHO HAVE SEEN YOU OR ARE SEEING YOU?

Name _____ Specialty _____

Name _____ Specialty _____

Name _____ Specialty _____

Name _____ Specialty _____

Name _____ Specialty _____

IF ANY OTHER FAMILY MEMBERS ARE PATIENTS IN THE ALLERGY SECTION, PLEASE LIST THEIR NAMES:

Thank you very much for completing this questionnaire.

REVIEWED BY: _____ DOCTOR'S SIGNATURE _____ DATE _____