Patient Questionnaire

Fax to: 281.647.9198

Patient Name: _____ Date of Birth: _____ Date: _____

	Y	N	UNSURE
Do you have trouble with your skin?			
eczema?			
hives?			
Do you have trouble with your ears?			
itching?			
popping?			
recurrent infections?			
Do you have trouble with your throat?			
itching?			
post-nasal drip?			
recurrent infections?			
Do you have trouble with your eyes?			
itching?			
puffiness?			
redness?			
tearing?			
Do you have trouble with your nose?			
stuffiness?			
decreased sense of smell?			
snoring?			
sneezing?			
drainage when eating?			
Do you have trouble with your sinuses?			
pressure?			
recurrent infections?			
headaches?			

Which of the following provoke your symptoms?	Y	N	UNSURE
at home			
at work			
indoors			
outdoors			
change in weather			
air conditioning			
damp areas			
mowing the lawn			
exposure to cats			
exposure to dogs			
smoke			
perfume			
paints			
eggs			
milk			
wheat			
soy beans			
peanuts			
white fish			
shellfish			
fruits			
vegetables			

Chest symptoms?			
cough?			
cough with exercise?			
shortness of breath?			
wheeze?			
recurrent bronchitis?			
history of pneumonia?			

House or other?_____ How old is the residence?_____ How long lived there?_____

Central AC/heat?_____ Mostly carpet, wood or tile?_____ Anyone smoking in house?_____

Cats or dogs at home? (circle)____ inside or outside? (Circle) _____ other pets/animals?_____

Bedroom: box spring/mattress or other type of bed?_____ Pillows: synthetic or feather:_____

List of Medications you are taking:_____

_____

_____

Medication allergies: _____ type of reaction? _____