Allergy & ENT Associates - Established Patient Questionnaire

Patient Name _____ **Date of Birth** _____ **Today's date** _____

Reason for Visit:

□ Allergy Test □ Routine Follow up

□ Immunotherapy Re-evaluation □ Sick/ill Visit □ Other_____

Chief Complaint:

□ Sinus Problems □ Cough □ Asthma/Breathing problem

□ Rash/Skin problems □ Allergies

□ Other _____

Since your last visit

Have you been satisfied with your health? □ Yes □ No

Have your medications caused any problems? □ Yes □ No

If yes, what problems did they cause? (Mark all that apply)

□ sleeplessness □ drowsiness □ nervousness □ headache

□ shakiness □ sore throat □ cough

□ other _____

Are you taking allergy shots? □ Yes □ No

If yes, have you had any problems with your shots? □ Yes □ No

If yes, what problems have you had? (Mark all that apply)

□ large local reactions □ pain □ rash □ breathing problems

□ other _____

Has your family or medical history changed? □ Yes □ No

If yes, list any changes: _____

Has your social history changed? (occupation, alcohol, drug use etc.) □ Yes □ No

If yes, list any changes:

Have you ever used tobacco? □ Yes □ No □ Unknown

Passive/Second hand smoke exposure? □ Yes □ No Who/Where: _____

Have there been any significant changes in your home or work environment? □ Yes □ No

If yes, list any changes: _____

If you have already had allergy testing, have you made changes in your home or behavior as suggested for controlling the allergens to which you are exposed? □ Yes □ No

If yes, list any changes: _____

Have you had breathing problems or asthma symptoms including coughing, wheezing, or shortness of breath over the past 2-4 weeks (not just with acute attacks)? □ Yes □ No

Number of Daytime Symptoms: _____ **Frequency** □ **Daily** □ **Weekly** □ **Monthly**

Number of Night Time Symptoms: _____ **Frequency** □ **Daily** □ **Weekly** □ **Monthly**

Since your last visit has your asthma been…. □ **Better** □ **Worse** □ **No Change**

Has your asthma or breathing problem caused you to miss work, school, or change your activities? □ Yes □ No

Have you had any emergency room visits or hospital stays? □ Yes □ No

Do you have any problems you wish to discuss? □ Yes □ No

If yes, please list the problems to discuss:

Current Medications

Please list your prescription, non - prescription, herbal drugs, creams, sprays, pills, liquids, or drops.

Medication Name	Dose	Frequency

Medication Allergies

Do you have any drug allergies or intolerance to medications? □ Yes □ No

Medication Name	Type of Reaction	When/Date

Nasal Rinse

Are you using a nasal saline rinse □ **Yes** □ **No**

IT Frequency

If you are taking allergy shots - how often do you receive the shots?

□ **once a wk** □ **twice a wk** □ **every 2 wks** □ **every 3 wks** □ **every 4 wks** □ **every 6 wks**

Other Notes:

Current Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____ **Street**

_____

City **State** **Zip**

Pharmacy Phone #: _____

Pharmacy Fax #: _____

Prescription Type: □ **90 day mail in** □ **Local** □ **Mail & Local**