Allergy & ENT Associates	ENT	New Patient Questionnaire P.1 Location: _____

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

Referring Physician _____ Accompanied Today By _____

Other Family Members Who Are AAA Patients _____

In the boxes below - please mark all that apply.

Reason(s) for Visit

- ☐ sinus infections
- ☐ nasal congestion
- ☐ nasal structure problem
- ☐ ear problems
- ☐ headaches
- ☐ throat infections
- ☐ chronic cough/ chest infections
- ☐ vocal cord problem
- ☐ neck/swallowing problems/thyroid problem
- ☐ trauma
- ☐ cosmetic concerns
- ☐ Other: _____

First time problems occurred? _____ (date)

When did this specific episode start? ☐ 1 week ago ☐ 2 weeks ago ☐ 3 weeks ago ☐ 4 weeks ago ☐ more than a month ago ☐ unknown

How often does this problem occur? ☐ everyday ☐ once per week ☐ 2 x per week ☐ monthly ☐ several times a year ☐ unpredictable

Which month(s) is it most severe? ☐ Jan ☐ Feb ☐ March ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec ☐ All year

What time of day are the symptoms worse? ☐ morning ☐ noon ☐ afternoon ☐ nighttime ☐ all the time

Are symptoms worse in certain locations? ☐ home ☐ work ☐ outside ☐ indoors ☐ other: _____

Suspected cause of problems? ☐ allergens ☐ structural defect ☐ trauma ☐ chronic infections ☐ weather changes ☐ swollen tissue ☐ tumor ☐ swollen gland ☐ other : _____

How would you grade the degree of your symptoms in the last 4 weeks? ☐ none ☐ mild ☐ moderate ☐ severe

How would you grade your degree of symptoms today? ☐ none ☐ mild ☐ moderate ☐ severe

How long have you lived in the area? _____ ☐ days ☐ week(s) ☐ year(s)

Moved from where? _____

Where did you grow up? _____

Patient Name | Date of Birth | Today's date

Review of Symptoms I

Please grade each of the following symptoms. (Mark all that apply)

		None	Mild	Moderate	Severe
Allergy/Sinus Symptoms	Dark circles under eyes:	☐	☐	☐	☐
	Itchy/watery eyes:	☐	☐	☐	☐
	Red eyes:	☐	☐	☐	☐
	Swollen/puffy eyelids	☐	☐	☐	☐
	Ear infections:	☐	☐	☐	☐
	Ear pain/pressure:	☐	☐	☐	☐
	Ear popping:	☐	☐	☐	☐
	Congestion/blocked nose:	☐	☐	☐	☐
	Decreased sense of smell:	☐	☐	☐	☐
	Nasal/sinus drainage:	☐	☐	☐	☐
	Nose bleeds:	☐	☐	☐	☐
	Runny nose:	☐	☐	☐	☐
	Sinus infection:	☐	☐	☐	☐
	Sinus pressure/pain:	☐	☐	☐	☐
	Sneezing:	☐	☐	☐	☐
	Snoring:	☐	☐	☐	☐
	Snorting:	☐	☐	☐	☐
	Sore throat:	☐	☐	☐	☐
	Hoarseness:	☐	☐	☐	☐
	Post nasal/throat drainage:	☐	☐	☐	☐
	Throat clearing:	☐	☐	☐	☐

		None	Mild	Moderate	Severe
Neurological Symptoms	Dizziness:	☐	☐	☐	☐
	Fatigue/tired:	☐	☐	☐	☐
	Headache:	☐	☐	☐	☐
	Lightheadedness:	☐	☐	☐	☐
	Problems sleeping:	☐	☐	☐	☐
	Poor concentration:	☐	☐	☐	☐
	Sleep apnea:	☐	☐	☐	☐

		None	Mild	Moderate	Severe
Asthma Symptoms	Croup/laryngitis:	☐	☐	☐	☐
	Chest infections:	☐	☐	☐	☐
	Chest tightness:	☐	☐	☐	☐
	Cough:	☐	☐	☐	☐
	Cough productive of mucus:	☐	☐	☐	☐
	Congestion:	☐	☐	☐	☐
	Shortness of breath (SOB):	☐	☐	☐	☐
	SOB with exercise:	☐	☐	☐	☐
	SOB at night:	☐	☐	☐	☐
	Wheezing:	☐	☐	☐	☐

Patient Name | Date of Birth | Today's date

Review of Symptoms I - Continued

Please grade each of the following symptoms. (Mark all that apply)

		None	Mild	Moderate	Severe
Skin Symptoms	Dry skin:	□	□	□	□
	Eczema:	□	□	□	□
	Hives:	□	□	□	□
	Itchy skin:	□	□	□	□
	Rash:	□	□	□	□
	Skin swelling:	□	□	□	□

		None	Mild	Moderate	Severe
Gastrointestinal Symptoms	Constipation:	□	□	□	□
	Diarrhea:	□	□	□	□
	Heartburn/Indigestion/Reflux:	□	□	□	□
	Nausea:	□	□	□	□
	Vomiting:	□	□	□	□

Other:	

Review of Symptoms II

(Mark all that apply)

General:	□ fever □ chills □ night sweats □ weight loss □ weight gain
Ears:	□ drainage □ hearing loss □ rupture of eardrum
Eyes:	□ burning □ dry
Mouth:	□ bad breath □ gum problems □ lip swelling □ tongue swelling □ pain in teeth □ teeth grinding □ mouth itching □ mouth ulcers
Throat:	□ difficulty swallowing □ swelling □ loss of voice
Chest:	□ chest pain □ heaviness/pressure □ heart palpitations
Urinary:	□ excessive urination □ excessive thirst □ pain/burning with urination □ difficulty with urination
Extremities:	□ swollen joints □ painful joints □ athletes foot/nail fungus
Neurological:	□ anxiety □ stress □ depression □ numbness/tingling □ tremors □ developmental/growth delay □ heat or cold intolerance
Other:	

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Patient Name | Date of Birth | Today's date

Asthma History

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

# of daytime symptoms:_____ Frequency □ daily □ weekly □ monthly

# of night time symptoms:____ Frequency □ daily □ weekly □ monthly

Sinus History

1. Do you have sinus problems? □ Yes □ No

If No - Go to Allergy History Section

2. How many times have you been treated for a sinus infection with an antibiotic in the past year?
   □ none □ 1 x □ 2 x □ 3 x or more

List previous antibiotics used for these infections:_____

3. What is the color of your nasal drainage? (Mark all that apply)
   □ clear □ brown □ white □ green □ yellow □ blood - tinged
4. Have you ever had nasal polyps? □ Yes □ No
5. Have you ever had an x-ray or CT scan of your sinuses? □ Yes □ No
   When was x-ray/scan done?
   Where was x-ray/scan performed? _____
6. Have you ever had sinus surgery? □ Yes □ No
   When was the sinus surgery?
   What type of surgery was it? □ caldwell luc □ ethmoidectomy □ graft □ rhinoplasty □ septoplasty □ turbinectomy □ other:_____
   Who was the surgeon?
   Did the surgery help? □ Yes □ No □ Somewhat
7. Do the sinus problems disturb your sleep enough to cause fatigue, tiredness or sleepiness during the day? □ Yes □ No

General Other:

Allergy History

1. Do you experience the following:
   hay fever/nasal allergies □ Yes □ No
   age when allergies/hay fever began? □ not sure
2. Have you ever been tested for allergies? □ Yes □ No

If No - Go to question # 3

How long ago was the test? □ less than one year □ 1-3 years □ 4 or more years □ Don't remember

What were you allergic to? (Mark all that apply) □ trees □ weeds □ grasses □ mold □ dust mites □ cats □ dogs □ foods □ insects □ latex

Did you get allergy shots? □ Yes □ No

How long did you take the shots? _____ □ Years □ Months □ Weeks

If yes, were the shots helpful? □ Yes □ No

Who was your doctor?

Where can we obtain your test results?

Other:

Social History

Have you ever used tobacco?	□ Yes	□ No	□ Unknown
Passive/second hand smoke exposure	□ Yes	□ No	Who/Where:
Do you drink alcohol?	□ Yes	□ No	
Recreational drug use?	□ Yes	□ No	
Do you have any HIV risk factors?	□ Yes	□ No	□ Not sure

Patient Name | Date of Birth | Today's date

General History

1. In the last 6 months, have you had a cough longer than 6 weeks in a row? □ Yes □ No
2. In the last 6 months, have you had hoarseness for greater than 6 weeks? □ Yes □ No
3. In the last 6 months, have you coughed up any blood or bloody sputum? □ Yes □ No
4. Have you had a chest x-ray in the last year? □ Yes □ No

   If yes, where was it performed? _____ When? _____

   What were the results? _____
5. During the last year, how many times have you had to take oral or injected steroids for allergies or sinus problems?

   □ none □ 1 x □ 2 x □ 3 x or more
6. During the last year, how many days have you missed school or work because of your allergies or sinus problems?

   □ none □ 1 day □ 2 days □ 3 x or more
7. During the last year, how many days have your allergies or sinus problems changed your productivity at work/school due to symptoms?

   □ none □ 1 day □ 2 days □ 3 x or more
8. How many times have you gone to the emergency room because of your allergies or sinus problems?

   □ none □ 1 x □ 2 x □ 3 x or more
9. How many times have you had to stay overnight at the hospital because of allergies or sinus problems?

   □ none □ 1 x □ 2 x □ 3 x or more
10. Are you pregnant? □ Yes □ No □ N/A

    Date of last menstrual period? ____/____/_____

Other:

Family History

Race? □ American Indian/Alaskan Native □ Asian □ Black □ Caucasian/white □ Hispanic □ More than one race □ Native Hawaiian/Other Pacific Islander □ Other □ Unknown/ not reported

Ethnicity? □ Hispanic/Latino □ Not Hispanic/Latino □ Unknown/Not reported

Preferred Language?

Are there any family disputes/divorce situations that may make patient care more difficult? □ Yes □ No

(Mark any family members who have experienced any of the listed conditions)

	Father	Mother	Brothers	Sisters	Son	Daughter
Allergies:	□	□	□	□	□	□
Autoimmune Disease:	□	□	□	□	□	□
Cleft Lip/Palate	□	□	□	□	□	□
Hearing Disorder:	□	□	□	□	□	□
Malignant Hyperthermia:	□	□	□	□	□	□
Migraine:	□	□	□	□	□	□
Sickle Cell Disease:	□	□	□	□	□	□
Sinusitis:	□	□	□	□	□	□
Sleep Apnea:	□	□	□	□	□	□
Thyroid Disease:	□	□	□	□	□	□
Cancer	□	□	□	□	□	□

Other:

Patient Name | Date of Birth | Today's date

Medical History

Please mark all that describe your current or past medical problems.

- □ Allergies
- □ Anemia
- □ Anesthesia Complications
- □ Asthma
- □ Bleeding Disorder
- □ Cancer
- □ COPD
- □ Coronary Artery Disease
- □ Diabetes
- □ GERD
- □ Hearing Loss
- □ High blood pressure/ Hyperten
- □ Kidney Disease
- □ Liver Disorder/Hepatitis
- □ Migraines
- □ Otitis Media/Ear Infections
- □ Seizure Disorders
- □ Sleep Apnea
- □ Stroke
- □ Tinnitus
- □ Vertigo

Please list all previous hospitalizations/surgeries/prosthetics devices (artificial limbs).

Description	Year

Other:

Pharmacy Information

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Street

_____

City State Zip

Pharmacy Phone #: _____

Pharmacy Fax #: _____

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

Patient Name | Date of Birth | Today's date

Medication History

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

Current Medications

Medication name	Dose	Frequency

Medication Allergies

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

Medication Allergies:

Medication name	Type of reaction	When/date

Other Notes: