

QUESTIONNAIRE

Name: _____ Date: _____
 Address: _____ Sex: M F Age: _____
 Number of years in So. CA _____ Occupation _____
 Other cities of residence and dates? 1. _____ 2. _____ 3. _____
If the patient is a child: Father's age: _____ Occupation: _____ Hobbies: _____
 Mother's age: _____ Occupation: _____ Hobbies: _____

A: MAJOR REASON FOR VISIT? Asthma Occupation lung disease Sinus disease Immunodeficiency Rash

In your own word detail the patient's most distressing symptoms. Be complete as to how long symptoms have been present, how severe they are, and if you suspect any specific agent that triggers them.

B: MEDICAL HISTORY

1. General health: Excellent Good Fair Poor 2. Weight change: Stable Gain Loss Amt: _____
 2. As an INFANT OR CHILD did the patient have any of the following:
 milk allergy diarrhea colic vomiting skin rashes croup bronchiolitis bronchitis pneumonia
 3. Immunizations: Up to date? Yes No Reactions to these shots? Yes No If yes, list: _____
 4. Does the patient have any other medical problems (*check all that apply*):
 blood pressure angina heart disease diabetes anemia transfusion tuberculosis
 jaundice liver disease bladder or kidney infection kidney stones kidney disease gall stone cancer
 convulsions prostate issue glaucoma fainting spells fatigue irritability pneumonia
 thyroid problem difficulty sleeping frequent depression
 5. List any hospitalizations (reason, date, place): _____

C: ASTHMA HISTORY

Asthma Severity: mild moderate severe
 Frequency of daytime: daily >2x/week <2/x week
 Frequency of nighttime symptoms: nightly >2x/month <2x/month
 Number of attacks per month? _____ Number of ER visits in the last 12 months? _____
 Days lost from work or school? _____ Number of hospitalizations? _____ Number of ICU stays? _____

D: SURGICAL HISTORY

Has the patient had any of the following: tonsillectomy adenoidectomy nasal septum repair nasal polyp removal
 sinus surgery chest surgery ear tubes Other _____

E: ALLERGY TREATMENT

Has the patient been tested for allergies? Yes No. If so, when and by who _____
 If tested, was it positive? Yes No If yes, what? Grass weeds trees mold animal dander dust mite foods
 Has the patient had allergy shots? Yes No If yes, what doctor? _____ From _____ to _____
 How long were the shots given? _____ Did they help? No Some improvement Much improvement
 Were there any serious reactions from allergy shots? Yes No

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F: MEDICATIONS: List all current medications (prescription, over-the-counter, herbal or vitamins)

Name					
Dose					
Frequency					
Did it help?					

List other medications that you are taking: _____

Have you ever taken oral or systemic steroids? Yes No Last dose? _____

G: FAMILY HISTORY: Please place a check in the box if the patient's family member has the condition.

	Father	Mother	Brother	Sister	Paternal Grandparent	Maternal Grandparent	Paternal Aunt/Uncle	Maternal Aunt/Uncle	Son/Daughter
Hay fever									
Sinus									
Asthma									
Hives or swelling									
Eczema									
Food allergy									
Drug allergy									
Insect allergy									
Emphysema									
Tuberculosis									
Diabetes									
Serious infection									
Death in first 2 years of life									

H: ENVIRONMENT:

Do you live in a: house apartment townhouse/condo. How long? _____ How old is your home? _____

Does your home have a: crawlspace basement attic Any water damage? Yes No

Check if you have any of the following animals at home and fill in how long you have had them.

cat _____ dog _____ guinea pig _____ horse _____ pigeons _____
 rabbit _____ hamsters _____ mice/rats _____ others (list) _____

List other animals that patient is exposed to regularly: _____

Do the pets sleep in the bedroom? Yes No

If the patient is a child, is the bedroom shared? Yes No

In the bedroom:

Does patient have any of the following in the bedroom (check all that apply):

- | | | |
|---|---|--|
| 1. <input type="checkbox"/> stuffed toys | <input type="checkbox"/> stuffed furniture | <input type="checkbox"/> potted plants. |
| 2. <input type="checkbox"/> radiator | <input type="checkbox"/> wall furnace | <input type="checkbox"/> floor furnace |
| 3. <input type="checkbox"/> evaporative cooler | <input type="checkbox"/> air purifier | <input type="checkbox"/> vaporize |
| 4. <input type="checkbox"/> curtains | <input type="checkbox"/> drapes | <input type="checkbox"/> shutters/blinds |
| 5. <input type="checkbox"/> room air conditioning | <input type="checkbox"/> central air conditioning | How often are the filters changed? _____ |
| 6. <input type="checkbox"/> wall to wall carpet | <input type="checkbox"/> area rug | other floor material? _____ |
| 7. <input type="checkbox"/> shelves | <input type="checkbox"/> bookshelf | List other furniture in bedroom _____ |
| 8. <input type="checkbox"/> box spring & mattress | <input type="checkbox"/> bunk beds | <input type="checkbox"/> foam mattress <input type="checkbox"/> waterbed <input type="checkbox"/> plastic covered mattress |
| 9. <input type="checkbox"/> quilt or chenille | <input type="checkbox"/> bedspread, | <input type="checkbox"/> down comforter <input type="checkbox"/> sleeping bag <input type="checkbox"/> wool blankets |
| 10. <input type="checkbox"/> Dacron pillow | <input type="checkbox"/> feather pillow | <input type="checkbox"/> kapok <input type="checkbox"/> foam rubber <input type="checkbox"/> polyester pillow |

Patient smoked? Yes No If yes: present past What? cigarettes pipe cigar

Amount: _____ How long? _____ What year did you quit _____

Is the patient is exposed to cigarette smoke at home? Yes No If yes: Indoors Outdoors

For the patient, are the mattress, bed and pillows encased in allergy covers? Yes No

In the patient's neighborhood:

What trees are in found the patient's neighborhood? _____

What structures are found near the home? (circle all that apply): factories, dairy barns, stables, freeway, empty lots

At work does the patient have exposure to (circle all that apply): chemical fumes, large amounts of dust, mold or mildew

Has the patient had significant past exposure to chemical fumes: Yes No If yes, explain: _____

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I: AGGREVATING FACTORS: Check the box that coincides with aggravating factor and the symptoms that are made worse by that factor. If the item is not factor then leave it blank.

	HAYFEVER	SINUS	EYES	ASTHMA OR BRONCHITIS	HIVES OR ECZEMA	OTHER (List)
SAME ALL YEAR						
JANUARY						
FEBRUARY						
MARCH						
APRIL						
MAY						
JUNE						
JULY						
AUGUST						
SEPTEMBER						
OCTOBER						
NOVEMBER						
DECEMBER						
MORNING						
AFTERNOON						
EVENING						
NIGHT						
COLD						
HEAT						
WIND						
SANTANA WINDS						
RAIN/ FOG						
SMOG						
HOUSE DUST						
MOWED GRASS						
YARD/PARK						
WEEDS						
TREES						
ANIMALS						
TOBACCO SMOKE						
COSMETIC ODORS						
AIR CONDITIONER						
WORSE AT HOME						
WORSE AT WORK/SCHOOL						
WORSE AT BEACH						
WORSE ON TRIPS						
FATIGUE						
RUNNING						
LAUGHTER						
TENSION/EXCITEMENT						
ALCOHOLIC BEVERAGES						
ANTIHISTAMINES						
PREGNANCY						
MENSTRUAL PERIODS						

J: RELIEVING FACTORS

List those factors that make the symptoms better (not including meds): _____

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K: REVIEW OF SYSTEMS: Circle the appropriate words that apply to any symptoms that you have experienced and place a check in the box that corresponds to the organ system involved with those symptoms.

- FREQUENT HEADACHE Related to nasal symptoms: frontal, sides, back, relief with aspirin
- EAR PROBLEMS Mild, moderate, severe, improving, same, worse, itch, drainage, blockage, popping, frequent infections, hearing loss, fluid in middle ear, ruptured ear drum
- EYE PROBLEM: Mild, moderate, severe, improving, same, worse, red, itch, tear, swelling, pain discharge, crusting, change in vision
- NASAL PROBLEM: Mild, moderate, severe, improving, same, worse, sneeze, itch, sniffles, watery discharge, colored discharge, blocked, sinus infections, snores, nose bleed, post nasal drip, polyps, broken nose, loss of sense of smell
- MOUTH AND THROAT: soreness, frequent throat clearing, frequent tonsillitis, itch of throat, hoarse, cold sores, swollen neck glands, difficulty swallowing
- CARDIAC: Turning blue, chest pressure, heart attack
- URINARY: Dark urine, pain with urination, blood in the urine.
- SKELETAL Joint pain, joint swelling,
- ECZEMA, HIVES, OR SWELLING Aggravating factors: sun cold physical activity nerves foods (list) _____
- OTHER SKIN PROBLEM: Dryness, itch with rash, easy bruising, small bumpy rash
- ABNORMAL CHEST X-RAY: Dates: _____
- CHOKING SPELL: Peanut, popcorn, other (list) _____
- POSITIVE TEST FOR TB OR VALLEYFEVER
- CHRONIC COUGH: Daily, more than 3 months per year, clear phlegm, colored phlegm, dry blood, brown or black specks, daytime, nighttime, How many years? _____
- STOMACH OR INTESTINAL PROBLEMS: Loss of appetite, nausea, vomiting, diarrhea, ulcers, abdominal pain, black or bloody bowel movement, abnormal bowel movement, heartburn
- INSECT ALLERGY: Bee, yellow jacket, hornet, wasp, other _____
Type of reaction _____ Last reaction _____
- DRUG ALLERGY: Aspirin, penicillin, sulfa, x-ray dyes, Novocaine, other _____
Describe reaction: _____
Last reaction? _____
- FOOD ALLERGIES: Milk, eggs, wheat, fish, chocolate, peanut, other nuts, orange, tomato, other _____
When was the last reaction? _____
Describe reaction: _____