ROCKY MOUNTAIN
ALLERGY ▪ ASTHMA
IMMUNOLOGY

Instructions: Please answer the following questions as completely and accurately as possible. The parent should fill out the form for patients under the age of 15.

Patient Questionnaire

Today's Date_____

Patient's Name_____DOB_____Sex: M F

How did you hear about our clinic or who were you referred by:_____

Reason for Allergy visit (briefly describe):_____

_____

A. Please check the conditions that have bothered you in the last 12 months:

Nose:
___Stuffy
___Sneezing
___Itching
___Draining
___Bleeding
___Mouth breathing
___Snoring
___Loss of smell
___Frequent sinus infections

Eyes:
___Itching
___Burning
___Watering
___Swelling

Throat:
___Itching
___Draining
___Throat clearing
___Soreness
___Hoarseness
___Loss of taste

Ears:
___Itching
___Popping
___Draining
___Ringing
___Hearing loss
___Fluid behind eardrums
___Frequent ear infections

Respiratory:
___Cough
___Wheeze
___Shortness of Breath
___Tightness
___Phlegm (mucus)
___Bronchitis
___Pneumonia

Gastrointestinal:
___Abdominal pain
___Vomiting
___Diarrhea
___Constipation
___Poor appetite
___Poor weight gain
___Heartburn/acid reflux

Nervous system:
___Headache
___Unusual tiredness
___Irritability

Skin:
___Hives
___Itch
___Swelling

Musculoskeletal:
___Muscle pains
___Joint pains

Cardiovascular:
___ heart racing
___ chest pain

Constitutional:
__ Fevers

Allergy:
__ food allergy

Endocrine:
__ heat/cold intolerance

Other symptoms not listed above:_____
_____
_____

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History of Present Illness:

	Nose/Eye	Chest	Skin
When did these symptoms begin (year)?	_____	_____	_____
Where did these symptoms begin (state)?	_____	_____	_____
When did these symptoms occur last (date)?	_____	_____	_____
What time of day are these symptoms worse?	_____	_____	_____

Underline the month(s) your symptoms occur. Circle the months that are worst.

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

B. What medications or treatments have you taken in the <u>past</u> for your allergies and/or asthma?

	Helpful yes	Helpful no		Helpful yes	Helpful no
1._____	___	___	5._____	___	___
2._____	___	___	6._____	___	___
3._____	___	___	7._____	___	___
4._____	___	___	8._____	___	___

C. Please list <u>all</u> your <u>current</u> medications and reasons for taking them:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

D. Have you ever been on allergy shots (immunotherapy)? If yes, when, for how long, and to what?

_____

Past Medical History

E. Please list any medication allergies including a description of any reactions:

_____
_____
_____

F. Please list any past or current medical problems not yet mentioned above, including any surgeries:

_____
_____
_____
_____

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G. Please list any medical problems that run in your immediate family:

Relationship (mother, brother, daughter, etc.)

Asthma: _____

Hay Fever or Allergic Rhinitis: _____

Eczema: _____

Immunodeficiency of any type: _____

Any other medical problems in the family:

_____ _____

_____ _____

_____ _____

***H.* Personal History:**

Do you smoke? _____ How many packs per day? _____ How long have you smoked? _____

Does anyone smoke at home or work? _____

Do you have any pets? If yes, type (cat, dog, etc.) and number.

_____

What is your occupation? _____

What is your exercise routine? _____

If the patient is a young child, does he/she attend daycare? _____

Signature _____ Date_____.

Please email this completed form to breatheeasy@rmallergy.com fax it to 801-775-9806, or bring it with you 15 minutes prior to your first visit. Thank you!