HNA Allergy & Asthma

Patient Questionnaire

Name:_____ DOB: _____ Date:_____

	Mother	Father	Siblings				Children			
Age (if alive)										
Health(good/bad)										
Cancer										
Tuberculosis										
Diabetes										
Heart Issues										
Hypertension										
Stroke										
Epilepsy										
Nervous Breakdown										
Asthma, hives, hayfever										
Blood disease										
Age (at death)										
Cause of death										

Personal History

Please **circle** symptoms that apply to why you are being seen by us today:

Constitutional:
Abnormal weight change
Fever
Chills
Fatigue

Respiratory:
Snoring
Wheezing
Shortness of breath

Cardiovascular:
Chest Pain
Palpitations

Gastrointestinal:
Abdominal Pain
Constipation
Diarrhea
Vomiting

Ear/Nose/Throat:
Hearing Loss
Ear Pain
Excessive ear wax
Hearing noises in ear
Dizziness
Trouble swallowing
Change in Voice
Throat Pain
Post-nasal drip
Nosebleeds
Nasal Congestion
Headache
Jaw pain

Neurological:
Trouble walking
Non-restorative sleep
Fainting
Tingling

Psychological:
Increased anxiety
Depression
Behavior changes
Increased stress

Musculoskeletal:
Neck stiffness
Increased muscle pain
Increased joint pain
Muscle weakness

Genitourinary:
Change in urinary color
Increased urgency
Blood in urine
Pain when urinating

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Past Medical History: Please **check** what you have been diagnosed with

- ☐ Anesthesia Complications
- ☐ Anxiety
- ☐ Asthma
- ☐ Kidney disease
- ☐ Bleeding Disorders
- ☐ Cataracts
- ☐ Congestive Heart Failure
- ☐ Cancer: Type_____
- ☐ Diabetes: Type_____
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heartbeat
- ☐ Immune Suppression
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Reflux (GERD)
- ☐ Enlarged glands
- ☐ Irregular bowel movements

Please list any other medical conditions: _____

_____

_____

Please list all **Allergies** (i.e. medications, foods, household products, etc)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Please list **ALL** surgeries **AND** hospitalizations:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Please list **ALL** diagnostic/radiological tests and **WHY** they were done:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you exercise adequately? **NO** **YES, how?**_____

Do you sleep well? **NO** **YES**

How many hours per night do you sleep? _____

Do you have regular bowel movements?_____

Is sex satisfactory? **NO** **YES**

Do you like your work? **NO** **YES**

Do you work Indoors or outdoors?_____

How many hours a day do you watch TV? _____

How many hours a day do you read? _____

How many weeks in a year do you take vacation? _____

Have you ever been treated for alcoholism? **NO** **YES**

Have you ever been treated for drug abuse? **NO** **YES**

Please list **ALL** medications/supplements you take:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Do you often feel any of the below emotions?

- □ Depressed
- □ Anxious
- □ Irritable
- □ Jumpy
- □ Jittery
- □ Trouble concentrating

WOMEN ONLY

Age at onset of menstrual cycle: _____ Usual duration of menstrual cycle: _____

Date of last period: _____ Are you regular? **No** **Yes**

Are you: **Heavy** **Medium** **Light**

Do you have **Tension or Depression** before your cycle? _____

Do you have **Cramps or Pain** associated with your cycle? _____

Do you have hot flashes? **NO** **YES**

Children born alive: _____ Still born: _____ Miscarriages: _____

Children born from cesarean: _____ Premature: _____ Vaginal:_____

Were there any pregnancy complications? _____