# HNA Allergy & Asthma

## Patient Questionnaire

Name: _____ DOB: _____ Date: _____

Pharmacy Name & Address: _____ Pharmacy Phone: _____

Primary Care Doctor (first and last name): _____ Office Phone: _____

Doctor who referred you (first and last name): _____ Office Phone: _____

Other physicians caring for you: _____ Your Height: _____ Weight: _____

Reason for Visit today: _____ Date of Injury: _____

Covid-19 Vaccination Status ☐ Yes ☐ NO If yes, please provide us with a copy of your card.

Number of vaccine doses: _____. Date of Last dose: _____

## Personal History

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

How long have you experienced your symptoms? _____

Are symptoms worse during any particular season?_____ ☐ year-round?

**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
Nasal Congestion
Nosebleeds
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. _____

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. _____

Do you often feel any of the below emotions?

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

**Family History:**

| | 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 | | | | |