DIPLOMATE
BOARD OF INTERNAL MEDICINE
ALLERGY & IMMUNOLOGY

TEL: (210)226-3500 AMERICAN
FAX: (210)226-3638 AMERICAN BOARD OF

MICHEL N. LAHAM, M.D., F.A.C.A.A.I.
Asthma, Allergy & Immunology
METROPOLITAN PROFFESIONAL BUILDING - SUITE 362
1303 McCULLOUGH AVENUE
SAN ANTONIO, TEXAS 78212

NEW-PATIENT QUESTIONNAIRE

Name: ______________________________ Date: ______________

Age: ________________________ Sex: ___________ Marital Status: ____________

Occupation: __________________________________

Where were you born? ___________________________

Where did you grow up? __________________________

How long have you lived in this area? _________________________

Do you have, or have you ever had any of the following symptoms?
Please rate them as to their severity, at their worst.

	No	**Mild**	**Moderate**	**Severe**
Nasal Congestion.....................	_____	_____	_____	_____
Sneezing.................................	_____	_____	_____	_____
Watery runny nose..................	_____	_____	_____	_____
Itchy eyes................................	_____	_____	_____	_____
Itchy palate.............................	_____	_____	_____	_____
Itchy ears.................................	_____	_____	_____	_____
Post-nasal drainage.................	_____	_____	_____	_____
Sore throat..............................	_____	_____	_____	_____
Hoarseness.............................	_____	_____	_____	_____
Cough....................................	_____	_____	_____	_____
Thick mucus...........................	_____	_____	_____	_____

....	**No**	**Mild**	**Moderate**	**Severe**
Yellow/green mucus..............	_______	_______	_______	_______
Irritated eyes..........................	_______	_______	_______	_______
Bad breath............................	_	_______	_______	_______
Ear infections.......................	_______	_______	_______	_______
Sinus headaches.................	_______	_______	_______	_______

How long have you had those symptoms, altogether? ______________________

Are these symptoms seasonal? Yes______ No_______

Which seasons are worse? Spring_____ Summer_____ Fall_____ Winter_____

Are the symptoms worse: Outdoors_____ Indoors_____ No difference _____

Are they worse on: Clear windy days_____ Overcast, drizzly days_____ No difference_____

Are they brought on by any of the following?

....	YES	NO
Freshly cut grass............................	____	____
House dust....................................	____	____
Cats...	____	____
Dogs...	____	____
Musty odors.................................	____	____
Cigarette smoke...........................	____	____
Perfumes....................................	____	____
Hair sprays..................................	____	____

....**Section 2**

Do you have, or have you ever had any of the following symptoms?

....	YES	NO
Night-time coughing..............	____	____
Cough after exercise.............	____	____

.... YES NO

Difficulty breathing.................. ____ ____

Wheezing.............................. ____ ____

Do you smoke Cigarettes? Yes___ No___ How long have you smoked?____ How much?____

Did you ever smoke Cigarettes? Yes___ No___ When did you quit? _____________

Have you ever been diagnosed as having asthma? Yes____ No____

If yes, at what age did it begin?_____

If you had it as a child, did you outgrow it? Yes____ No____ At what age?____

What medications are you taking for it?__________________

....__________________

....__________________

...._ __________________

Do you use Albuterol? Yes____ No____

Are you taking Prednisone? Yes____ No____

Which seasons are worse? Spring____ Summer____ Fall____ Winter____

Can you take aspirin? Yes____ No____

If no, explain? ____

Is there anyone in your family with:

Relationship

Hay fever.. _______________

Asthma... _______________

Eczema... _______________

Sinusitis.. _______________

....**Section 3**

Do you suffer from hives, swelling of the face or lips? Yes____ No____

How long have you suffered from them? ____________

How often do you have them?_______________

Are your hives associated with:

Meals..Yes____ No____

Exercise...Yes____ No____

Heat...Yes____ No____

Cold...Yes____ No____

Pressure..Yes____ No____

Sunlight..Yes____ No____

Stress...Yes____ No____

Anxiety..Yes___ No____

Are you allergic to any foods that you know of? Yes______ No____

If yes, which ones? ____________________

................................____________________

................................____________________

................................____________________

Do you take any of the following medications on a regular basis?

Birth control pills Yes____ No____

Laxatives Yes____ No____

Aspirin Yes____ No____

Are you allergic to any specific medications?

Yes____ No____

Which ones?

____

____

____

____

....**Section4**

Do you have Glaucoma? Yes____ No____ What do you take for it?____________________

Do you have high blood pressure? Yes____ No____

What do you take for it? ________________________

If male and over 50, do you have prostate problems? Yes____ No____

What do you take for this? __________________

Did you have prostate surgery? Yes____ No____

THANK YOU.
PLEASE RETURN THE QUESTIONNAIRE TO THE RECEPTIONIST.

....**Section 5**

To be filled out by the doctor

PFR________ Predicted_________ P____ B/P________WT________ TEMP_____HT___

Physical Examination

Head- Normal_____

Sinus tenderness: Frontal____ Maxillary R___L___

Angioedema: Periorbital___ Lips: upper___ lower___

Eyes- PERRL____ Conjunctiva: Normal___ Swollen___ Inflamed___

Ears- (R) TM: Normal___ Red___ Bulging___ Retracted___ Scarred___ Cerumen___

(L) TM: Normal___ Red___ Bulging___ Retracted___ Scarred___ Cerumen___

Nose- Mucosa: Normal___ Swollen___ Pale___ Wet___ Inflamed___

Discharge: No___ Clear___ Yellow___ Green___

Septum: Midline___ Deviated to R___ L___

Throat-Normal___ Post-nasal drainage___ Inflamed___ Pus___

Tonsils: Normal___ T&A___ Enlarged___ Exudate___

Neck- Normal___ Lymphadenopathy___ Thyromegaly___

Chest- Normal___ Barrel-shaped___ Retractions___

Lungs: Clear___ Wheezing: Inspiratory___ Expiratory___

Rhonchi___

Rales___

Rubs___

Skin- Normal___ Urticaria___ Angioedema___ Rash__