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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.

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

.....	<u>No</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>
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?

.....	<u>YES</u>	<u>NO</u>
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?

.....	<u>YES</u>	<u>NO</u>
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 ___