GourleyAllergy

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 are currently bothering you:

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:

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

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

C. Circle the medications or treatments that you have taken in the <u>past</u> for your allergies and/ or asthma.

	How many months?					How many months?			
Advair	1	2	3	4	Fluticasone	1	2	3	4
Dulera	1	2	3	4	Nasonex	1	2	3	4
Flonase	1	2	3	4	Qvar	1	2	3	4
Flovent	1	2	3	4	Symbicort	1	2	3	4

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

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

F. Please list any <u>MEDICATION</u> allergies:

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

H. Please list any medical problems that run in your <u>immediate</u> family:

Relationship (mother, brother, daughter, etc.)

Asthma:
Hay Fever or Allergic Rhinitis:
Eczema:
Immunodeficiency of any type:
Any other medical problems in the family:

***I.* Personal History:**
Do you smoke? How many packs per day? __ How long have you smoked?
Does anyone smoke at home? At work?
Were you exposed to smoke as a child? If yes, for how long?
Do you have any pets? If yes, type (cat, dog, etc.) and number.

Signature _____ **Date** _

Please email this completed form to findrelief@gourleyallergy.com, fax it to 801-266-4138 or bring it with you 15 minutes prior to your first visit. Thank you!