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PATIENT HEALTH QUESTIONNAIRE

Today's date:	Referring Doctor:		
Patient's last name:	First:	Middle:	Birth date: / /

HISTORY

Reason for consulting the doctor (describe your symptoms and complaint:

How long have you had this problem?

How often does it occur? (times per day, week, etc.)

How long does it last? (hours, days, etc.)

Worse at night or day? Worse inside or outside?

Circle the month(s) it is most severe:

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

What makes it worse?

What makes it better?

Have you seen an allergist before? If so, please give details:

Are there places you have lived that make the symptoms better or worse?

Are there rooms in your house that make your symptoms worse?

Where do you work?

Are your symptoms better, worse or the same at work?

Do any of the following make your symptoms worse? (circle)

Heat Cold Exercise Weather changes Dampness Sun Damp basements Raking leaves Barns

Cutting grass Hay Drinking wine Drinking beer Eating cheese Sweating Vibration Pressure

PAST MEDICAL HISTORY

(if YES, please explain)

Allergies	NO	YES:
Asthma	NO	YES:
Sinus Problems	NO	YES:
Eczema or other Skin Rash	NO	YES:
Cataracts or Glaucoma	NO	YES:
Thyroid Disease	NO	YES:
Diabetes	NO	YES:

Rheumatoid Arthritis, Lupus	NO	YES:
High Blood Pressure	NO	YES:
Rhythm Disturbance of the Heart	NO	YES:
Other Heart Disease	NO	YES:
Liver Disease	NO	YES:
Kidney Disease	NO	YES:
Blood Clotting Problems	NO	YES:
Prostate Enlargement	NO	YES:
Surgery	NO	YES:
Childhood Illness (chickenpox, measles, etc.)	NO	YES:
Are you pregnant or planning to become pregnant in the near future?	NO	YES:
Other (describe)		
Last Menstrual Period		

Hospitalizations or Emergency Room visits within the last 3 years (when and why)

Current Medications, non-prescription drugs, and supplements (please note dose, number of times taken per day and start date). For patients with hives, anaphylaxis, drug allergy and angioedema, pleases include length of time.

ALLERGY HISTORY

Circle the drug(s) which have caused any adverse reaction:

Aspirin   Nonsteroidal Anti-Inflammatory Drugs (Motrin, Advil, etc.)   Nose Sprays   Penicillin   Sulfa Drugs

Other Antibiotics   Antihistamines   Bronchodilators (Albuterol)

Others: ____

What were the symptoms? ____

Foods	**Reaction (or Symptoms):**
Nuts: ______________________	
Peanuts	
Fish: ______________________	
Shellfish: ______________________	
Milk	
Eggs	

Wheat	
Soy	
Other: ______________________	
Mold	**Reaction (or Symptoms):**
Wine, Beer	
Cheese, Mushrooms	
Damp Basements, humid days, after rain	
Animals	**Reaction (or Symptoms):**
Cats	
Dogs	
Horses	
Insect stings, bites	
Other: ______________________	
Irritants	**Reaction (or Symptoms):**
House dust, dust or powders	
Fumes	
Perfumes	
Smoke	
Vaccinations (Diphtheria, Tetanus, Pertussis, or Whooping Cough, Polio, Measles, German Measles, Mumps, Influenza, Other)	**Reaction (or Symptoms):**
Other Substances	**Reaction (or Symptoms):**
Latex	
Radiocontrast Dye	
Nickel or other metal: ________________	
Poison Ivy	
Other: ______________________	

INFECTION HISTORY

Circle if you have had any of the following:

Blood Infection   Bronchitis   Pneumonia   Chickenpox   Shingles (zoster)   Hepatitis   HIV or AIDS   Meningitis

Sinusitis   Frequent or Lengthy Ear Infections   Frequent or Lengthy Upper Respiratory Tract Infections

Tuberculosis or Positive Tuberculin Skin Test   Abnormal Chest X-Ray   Abnormal Chest CT Scan

Abnormal Sinus CT Scan

FAMILY HISTORY

	Mother	Father	Siblings		Child	Other
Hay Fever						
Other Allergies						
Asthma						
Eczema						
Other________						

SOCIAL HISTORY

Do you or have you ever smoked? NO YES Packs per day? ______________ How Long? ______________
When did you quit? ______________

Do you drink alcohol? NO YES How much and how often? ____

Do you have any pets or exposure to animals? NO YES For How long? __________________________________

Do you have (check all that apply:
- ❑ Basement or garden apartment
- ❑ Water leak
- ❑ Flood damage
- ❑ Fire damage
- ❑ Excess mold or mildew
- ❑ Excess dust

Do you have (check all that apply):
- ❑ Forced air heating
- ❑ Radiator heating
- ❑ Electric heating
- ❑ Other heating
- ❑ Central air conditioning
- ❑ Swamp cooler
- ❑ Carpet
- ❑ Hardwood floors
- ❑ Other flooring___________________________
- ❑ Humidifier
- ❑ De-humidifier

Location (circle): Country Suburbs City Farm Other: ____

How long have you lived in your current location? __________________________ Age of home? ___________________

REVIEW OF SYMPTOMS

Check if any symptoms are currently or recently a problem:

General	❑ Weight Change	❑ Weakness	❑ Fatigue	❑ Change in alertness
Skin	❑ Rash	❑ Swelling	❑ Itching	❑ Change in pigment or texture
Head	❑ Headache ❑ Eye itching ❑ Runny nose ❑ Hoarseness	❑ Dizziness ❑ Eye redness ❑ Post nasal drip ❑ Sore Throat	❑ Loss of smell ❑ Tearing ❑ Nose bleeds ❑ Bad breath	❑ Sinus/facial pain or pressure ❑ Eye swelling ❑ Nasal congestion ❑ Change in gums
Heart	❑ Palpitations ❑ Leg swelling	❑ Skipped or irregular beats	❑ Chest or leg pain during exertion	❑ Beating too fast or too slow

Lungs	❑ Cough ❑ Change in sputum color	❑ Wheeze ❑ Coughing up blood	❑ Tightness ❑ Shortness of breath, ❑ if yes (circle) at rest, with exercise, when asleep	❑ Chest pain
GI	❑ Heartburn ❑ Vomiting	❑ Reflux ❑ Diarrhea	❑ Nausea ❑ Constipation	❑ Abdominal pain ❑ Food intolerance
GU	❑ Change in urination	❑ Blood in urine	❑ Difficulty or pain urinating	
M/S	❑ Joint pain ❑ Dry eyes	❑ Stiffness ❑ Dry mouth	❑ Joint swelling ❑ Change in color of fingers in cold	❑ Joint redness or heat
Hemat/Onc	❑ Bleeding	❑ Bruising	❑ Lumps	❑ Unexplained fever or night sweats
Neuro/Psych	❑ Depression	❑ Anxiety	❑ Sleep disturbances	
Endo	❑ Change in appetite or thirst	❑ Change in skin, hair or nails		
Females	❑ Premenopausal	❑ On birth control pills	❑ Postmenopausal	

Is there anything else you'd like your doctor to know today?