Allergy & Asthma Center of Southern Oregon, PC
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Appointments: 1.888.558.1003 Fax: 541.857.4499

Patient Questionnaire

Today's Date: _____ **Home Phone:** _____ **Cell Phone:** _____

Name: _____ **DOB:** _____ **Age:** _____ **M F**
Occupation: _____ **School:** _____ **Hobbies:** _____
Personal Information: _____
Ok to upload medications from your pharmacy: **Y N** **Pharmacy:** _____

Current Medical Symptoms (Circle all that apply):

Nasal Congestion	Itchy Eyes	Day Cough	Asthma or w/Exercise	Eczema	Headache
Post Nasal Drip	Watery Eyes	Night Cough	Wheezing	Skin Rash	Snoring
Sneezing	Reddened Eyes	Productive Cough	Shortness of Breath	Hives	Sleep Problems

Triggers for Symptoms (Circle all that apply): Dust Trees Grasses Weeds Pets Molds/Mildew Smoke Odors Perfumes Pollution

Circle Most Bothersome Months: **Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec**

Past Medical History (Circle all that apply):

Chronic Skin Disease	Asthma/Emphysema	Gastric Reflux (heartburn)	Depression
Headaches	Other Lung Disease	Intestinal Problems	Anxiety
Seizures/Strokes	High Blood Pressure	Diabetes	Chronic Fatigue Syndrome
Glaucoma	Heart Disease	Thyroid Problems	Fibromyalgia
Ear Tubes (Surgery?)	Hepatitis/Jaundice	Nasal Polyps (Surgery?)	

Other Conditions: _____

Food Intolerances: None Milk Eggs Wheat Corn Shellfish Fruits Nuts Others: _____
Insects Reactions: No Reactions Bees Mosquitoes Others: _____
Skin Contactants: No Reactions Poison Oak Metal Jewelry Others: _____
Past Surgical History: _____

Family History (Draw a line between the condition and the family member):
Asthma Hay Fever Eczema Hives Food Allergy Other Allergy Conditions in Family: _____

Mother Father Brother Sister Son Daughter Other Relatives: _____

Environmental History (Circle most bothersome months): **Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec**
Lived in present home: Yrs: _____ Age of Home: _____ Location: _____ Year Moved to Oregon: _____
In what geographic area have you spent most of your life? _____

Home Conditions (Circle all that apply):
Present Home: House Apartment Mobile Home Condo Other: _____
Present Home has: Forced Air Heat Wood Stove Wall/Baseboard Heater Air Conditioning
Are there: Damp Areas in Home Mold in the House Moisture under or in House Attic or Basement

Bedroom Products Used (Circle all that apply): Mattress Waterbed Bunk Bed Other: _____
Feather Pillow Feather Comforter Quilt Futon Wool/Electric Blankets Carpeted Window Open at Night: Y N
Do you use dust covers: Pillow: Y N Mattress: Y N

Pet History: Dogs: Y N How Many: _____ Indoors: Y N Outdoors: N Y Do they sleep in Bedroom? Y N
Cats: Y N How Many: _____ Indoors: Y N Outdoors: N Y Do they sleep in Bedroom? Y N
Other Pets or Animals: _____ Do you have exposure to barns or ranch animals? Y N

Are you on Allergy Shots: **Y N** **Year Started:** _____ **Maintenance** **Building** **Inhalants** **Venom**

Do you take a Beta Blocker: **Y N**

Smoking History: Did you ever smoke? Y N Year Started: _____ Packs/Day: _____ Did you Quit? Y N When: _____
Does anyone currently smoke inside your home? Y N Who: _____
Alcohol Use: Y N **Exercise:** Y N **Drug Use:** Y N **Aspirin Sensitive:** Y N

Medication Allergies/Intolerances: _____

Signature: _____ **Date:** _____