



**NEW PATIENT QUESTIONNAIRE**

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

**INFORMANT:**  Patient  Parent  Other **REFERRING PHYSICIAN:** \_\_\_\_\_

**PREFERRED PHARMACY AND NUMBER:** \_\_\_\_\_

Have any family members been seen in our office previously?  Yes  No **Name:** \_\_\_\_\_

**REASON FOR APPOINTMENT** (include location, severity, what time of day, duration of symptoms, modifying factors, associated signs/symptoms):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Current Medications:** (include dosage and frequency if known)

Prescription	Over the Counter	Vitamins/Supplements

**Drug Allergies:**

**Chronic or Past Medical Problems:** None

<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis (Type if known)
<input type="checkbox"/> Hayfever, Nasal Allergies	<input type="checkbox"/> COPD	<input type="checkbox"/> Other Liver Disease
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Sarcoidosis	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Eczema	<input type="checkbox"/> Other Lung Disease	<input type="checkbox"/> High Cholesterol and/or Triglycerides
<input type="checkbox"/> Hives	<input type="checkbox"/> Immunodeficiency	<input type="checkbox"/> Other Heart Disease
<input type="checkbox"/> Angioedema/Anaphylaxis	<input type="checkbox"/> AIDS	<input type="checkbox"/> Stroke
<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Insect Sting Allergy	<input type="checkbox"/> Diabetes <input checked="" type="checkbox"/> Type 1 <input checked="" type="checkbox"/> Type 2	<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Food Allergy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Eosinophilic Esophagitis
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Lupus	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Other Autoimmune Disease	<input type="checkbox"/> Epistaxis	<input type="checkbox"/> GERD
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Blood Clotting Disorder	<input type="checkbox"/> Barrett's Esophagitis
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Cancer – Type:	<input type="checkbox"/> Psychiatric Disease – Type:

Other Serious or Chronic Medical Problems:  None

**Tobacco Use:** ( Age 13 and over) Cigarettes  Never  Former Smoker # of years \_\_\_\_\_ Avg. # per day \_\_\_\_\_ Year Stopped \_\_\_\_\_  
 Current Smoker # of years \_\_\_\_\_ Avg. # per day \_\_\_\_\_

Other Tobacco  Former  Current Second Hand Smoke Exposure

**Alcohol Use:**  None # of drinks per day \_\_\_\_\_ per week \_\_\_\_\_ **Recreational Drug Use:**  None  Marijuana  Other

**PAST SURGERIES/HOSPITALIZATIONS:** (include year if known) **NONE**


NAME: \_\_\_\_\_

ACCT # \_\_\_\_\_

**FAMILY HISTORY:**

	Hearing loss	Asthma	apnea	sinusitis	Other Conditions
<b>Mother</b> <input type="checkbox"/> Living <input type="checkbox"/> Deceased					
<b>Father</b> <input type="checkbox"/> Living <input type="checkbox"/> Deceased					
<b>Sibling</b> #Living _____ #Deceased _____					
<b>Child</b> #Living _____ #Deceased _____					
<b>Other</b>					

**SYMPTOMS/PROBLEMS:** Do you CURRENTLY have or have you RECENTLY had any of the following?

<b>GENERAL</b> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Sweats <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Difficulty Sleeping
<b>EYES</b> <input type="checkbox"/> Itching <input type="checkbox"/> Redness <input type="checkbox"/> Watering <input type="checkbox"/> Dryness <input type="checkbox"/> Other
<b>EARS</b> <input type="checkbox"/> Pain <input type="checkbox"/> Plugged <input type="checkbox"/> Itching <input type="checkbox"/> Ringing <input type="checkbox"/> Recurrent Infections <input type="checkbox"/> Tubes <input type="checkbox"/> Other
<b>NOSE/SINUSES/THROAT</b> <input type="checkbox"/> Runny Nose <input type="checkbox"/> Postnasal Discharge <input type="checkbox"/> Stuffiness <input type="checkbox"/> Sneezing <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Nasal Polyps <input type="checkbox"/> Loss of Smell or Taste <input type="checkbox"/> Snoring <input type="checkbox"/> Sinus Pressure <input type="checkbox"/> Sinus Headache <input type="checkbox"/> Past Sinus or Nose Surgery <input type="checkbox"/> Sore Throat <input type="checkbox"/> Itchy Throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Throat Clearing <input type="checkbox"/> Other
<b>LUNGS</b> <input type="checkbox"/> Productive Cough <input type="checkbox"/> Non-Productive Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest Tightness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Difficulty breathing with exercise <input type="checkbox"/> Recurrent Bronchitis <input type="checkbox"/> Recurrent Pneumonia <input type="checkbox"/> Other
<b>SKIN</b> <input type="checkbox"/> Itching <input type="checkbox"/> Eczema <input type="checkbox"/> Hives <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other Rash <input type="checkbox"/> Allergy Swelling/Angioedema <input type="checkbox"/> Other
<b>GASTROINTESTINAL/DIGESTIVE</b> <input type="checkbox"/> Bloating <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Heartburn/Indigestion <input type="checkbox"/> Other
<b>BLOOD/LYMPH</b> <input type="checkbox"/> Lymph Node Swelling <input type="checkbox"/> Anemia <input type="checkbox"/> Other
<b>HEART</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Fast or Irregular Heart Rate <input type="checkbox"/> Fainting <input type="checkbox"/> Swelling of ankles/feet <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Other
<b>MUSCULOSKELETAL</b> <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscular Pain <input type="checkbox"/> Back Pain <input type="checkbox"/> Other
<b>ENDOCRINE</b> <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Unusual Hair Loss <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Rapid Weight Change <input type="checkbox"/> Other
<b>GENITOURINARY</b> <input type="checkbox"/> Painful or Frequent Urination <input type="checkbox"/> Frequent Urinary Infections <input type="checkbox"/> Other For Women: <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Menopausal For Men: <input type="checkbox"/> Prostate Problems
<b>NEUROLOGIC</b> <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Memory Loss <input type="checkbox"/> Learning Problems <input type="checkbox"/> Other
<b>PSYCHIATRIC</b> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Mood Swings <input type="checkbox"/> Agitation <input type="checkbox"/> Other

Please describe any other concerns regarding your health:

<b>ENVIRONMENTAL allergy history /SOCIAL HISTORY:</b>
<b>Home:</b> <input type="checkbox"/> House <input type="checkbox"/> Townhouse <input type="checkbox"/> Condo <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile Home
<b>Years in Georgia:</b> _____ <input type="checkbox"/> Native <b>Years in Current Home:</b> _____ Age of Home _____
<b>Heating System:</b> <input type="checkbox"/> Forced Air <input type="checkbox"/> Hot Water Baseboard <input type="checkbox"/> Other <b>Air Conditioning:</b> <input type="checkbox"/> None <input type="checkbox"/> Central <input type="checkbox"/> Window/Wall AC <input type="checkbox"/> Evaporative Cooler
<b>Flooring:</b> Living area <input type="checkbox"/> Carpet <input type="checkbox"/> Wood/Tile etc. <input type="checkbox"/> Wool Area Rug Bedroom <input type="checkbox"/> Carpet <input type="checkbox"/> Wood/Tile etc. <input type="checkbox"/> Wool Area Rug Basement <input type="checkbox"/> Cement <input type="checkbox"/> Subfloor <input type="checkbox"/> Carpet <input type="checkbox"/> Wood/Tile etc. <input type="checkbox"/> Crawl Space
<b>Mattress/Bedding:</b> <input type="checkbox"/> Spring <input type="checkbox"/> Foam/Latex <input type="checkbox"/> Air/Water Age of mattress _____ <input type="checkbox"/> Down pillows <input type="checkbox"/> Down Comforter <input type="checkbox"/> Down Mattress Topper
<b>Pets:</b> <input type="checkbox"/> None Dogs # _____ Cats# _____ Other _____
Do you suspect any home or work exposures are triggering symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Occupation:</b> _____
<b>Type of Workplace:</b> _____
<b>School:</b> _____

**PATIENT/PARENT SIGNATURE:** \_\_\_\_\_