ALLERGY, ASTHMA & IMMUNOLOGY CONSULTANTS, INC.
M.K. PUNJA, M.D.

PLEASE TAKE A FEW MINUTES TO ANSWER THE FOLLOWING QUESTIONNAIRE:

Today's Date _____

Patient's Name _____ Age _____

Please list all current medications and dosages: _____

_____

_____

Chief Complaint/How Long: _____

_____

PLEASE CIRCLE YOUR ANSWERS TO THE FOLLOWING QUESTIONS:

NASAL: Stuffiness, Sneezing, Itching, Runny Nose, Loss of Smell, Snoring, Polyps, Mouth Breathing

NASAL DISCHARGE: Clear, Colored, Thick, Watery

EYES: Itching, Redness, Swelling, Discharge, Watering, Burning

DO YOU WEAR CONTACT LENSES? YES / NO

THROAT: Itching, Drainage, Hoarseness, Loss of Voice Cough

SINUSES: Pain, Fullness/Pressure, Sinus Infections(how many per year_____)

HEADACHES: YES / NO *FREQUENCY:* _____ *MIGRAINES:* YES / NO

ARE SYMPTOMS SEASONAL OR YEAR-ROUND? _____

IF SO, WHAT MONTHS? _____

PAST SURGICAL TREATMENTS: NASAL / SINUS *OTHER SURGERIES:* _____

_____

OTHER CURRENT/PAST MEDICAL DIAGNOSES: _____

_____

- OVER -

SYMPTOMS ARE WORSENED OR BROUGHT ON BY:

Pollens, Dust, Pets, Mowing Grass, Raking Leaves, Cigarette Smoke, Foods, Perfumes, Changes in Weather, Humidity, Fumes (chemical, smog, auto exhaust, etc.), Temperature, Air-Conditioning

CHEST SYMPTOMS? YES / NO

IF YES, HAVE YOU HAD - Trouble Breathing, Wheezing, Asthma, Tightness in Chest, Bronchitis, Frequent Cough, Shortness of Breath or Wheezing with Exercise

SKIN SYMPTOMS: Rashes, Hives, Swelling, Itching, Eczema, Contact Allergy, Poison Ivy/Sumac

FAMILY HISTORY: (M-mother, F-father, S-sister, B-brother, C-children) Food Allergy _____

Hayfever _____ Asthma _____ Eczema _____ Sinusitis _____

ENVIRONMENTAL HISTORY:

Your Present Residence is: House, Apartment, Dorm, Mobile Home Other

Heating System: Central Heat, Fireplace, Wood Burning Stove, Hot Water/Radiant Heat

Cooling System: Central Air, Window A/C

Are there any indoor pets? YES / NO IF YES, WHAT TYPE? _____

Flooring in Bedrooms: Carpeted, Wood, Linoleum Tile Other

Do you have: Feather Pillows, Down Pillows, Wool Blankets, Down Comforter, Humidifier, Stuffed Toys

What is your Occupation? _____

Does anyone at home smoke? YES / NO

Do you smoke (if an adult)? YES / NO

DRUG ALLERGIES: YES / NO - TO WHAT? _____

_____

FOOD ALLERGIES: YES / NO - TO WHAT? _____

_____

INSECT STING ALLERGIES: YES / NO - TO WHAT? _____

PREVIOUS ALLERGY EVALUATION: YES / NO

HAVE YOU BEEN ON ALLERGY SHOTS IN THE PAST? YES / NO