PATIENT/FAMILY QUESTIONNAIRE

This questionnaire will enable your doctors to learn important medical information about you and your family so they can focus their evaluation and testing appropriately. Please answer the questions fully and return the questionnaire **two weeks before your visit.**

PATIENT/FAMILY MEDICAL HISTORY

Patient name _____ Date ____ / ____ / ____

Person filling out form: ❒ Patient ❒ Other: _____ Relationship to patient _____

Reason for coming to the clinic (problems, symptoms, etc.) _____

Current medications _____

_____

Allergies to medications _____

Patient's occupation: ❒ Works at _____ ❒ Retired from _____ ❒ Student in _____ grade

Have you been injured from a chemical-related incident (spill, pesticide, spray, etc.)? ❒ No ❒Yes-Explain: _____

Have you had any extensive dental work (root canals, mercury fillings, amalgams, etc.)? ❒ No ❒ Yes-Describe: _____

_____

Have you been treated or tested for allergies before? ❒ No ❒ Yes-When? _____

Have you had a strong reaction to allergy treatment or testing? ❒ No ❒ Yes-Explain: _____

Family Medical History	PATIENT	MOTHER	FATHER	GRANDPARENTS	SIBLINGS	AUNTS/UNCLES
Major illnesses (describe)						
Surgeries (describe)						
Allergies (describe)						

Additional family information _____

How much alcohol do you drink per day (____oz. beer ____oz. wine ____oz. liquor)

Describe your tobacco use (type of tobacco, amount used per day) _____

Do you travel extensively? ❒ No ❒ Yes-Do you travel by ❒ car ❒ plane ❒ other _____

ENVIRONMENTAL FACTORS

Tell us about the environments in which you spend time:

List average hours spent per day at:	Home ____	Work ____	School ____	Daycare ____	Other ____
How long have you lived/been going to this building (years)					
What is the age of the building? (years)					
Location (city/residential/industrial/town/rural/farm)					
Type of building (single family/apartment/mobile/office)					
Type of heating (forced air/hot water/radiant)					
Type of heating fuel (natural gas/LP gas/oil/electric/wood)					
Carpeting (shag/short pile/wall-to-wall/partial and age)					
Has there been water damage to this building? (yes/no)					
Was the building remodeled in the last two years? (yes/no)					
List dust or bug problems in this building (roaches; other insects)					
List pets at this building (dog/cat/bird)					

Comments to explain any items further _____

Check things in your environment that make you feel unwell (list specific products or items *and* describe your symptoms):

❒ Perfumes/aftershaves _____
❒ Soaps/detergents _____
❒ Cosmetics/deodorants _____
❒ Disinfectants _____
❒ Insect control products _____
❒ Pets/animals _____
❒ Soft plastics/vinyls/latex _____
❒ Cleaning fluids/sprays _____
❒ Household cleaning (dusting, etc.) _____
❒ Bed pillows _____
❒ Other _____

❒ Fabric store odors _____
❒ Newspaper print _____
❒ Downs/feathers _____
❒ Grass/pollen/trees _____
❒ Moldy areas/things _____
❒ Vehicle exhaust _____
❒ Natural gas _____
❒ Tobacco smoke _____
❒ Yard work (mowing grass, etc.) _____
❒ Insects (bees, wasps, mosquitoes, etc.) _____
❒ Other _____

MISCELLANEOUS INFORMATION

How good is your sense of smell? ❒ Above average ❒ Average ❒ Below Average ❒ None/gone-How long? _____

Do you feel worse during certain times of the year? ❒ No ❒ Yes-What Season ❒ Winter ❒ Spring ❒ Summer ❒ Fall

Have you been unable to work because of partial or total disability? ❒ No ❒ Yes-Give dates and reasons _____

_____

Do you feel that your allergy or illness is school or work related? ❒ No ❒ Not sure ❒Yes-Explain _____

Are you exposed regularly to ❒ Livestock ❒ Crops/fieldwork?

Are you exposed to fumes or chemicals at work or home? (Crop spraying, highway/factory pollution, etc.) ❒ No ❒ Not sure ❒Yes-Name chemicals and describe ill effects _____

What are your favorite hobbies? _____

Do your hobbies involve working with paint, glue, solvent or chemicals: ❒ No ❒ Yes-Describe _____

How many days of work or school did you miss last year (if applicable)? _____days. Primary Reason: _____

Circle any odors you smell when you enter your home: *gas* *musty odor* *mold* *chemicals* Explain: _____

Do you burn wood often? ❒ No ❒ Yes-Describe (open fireplace; wood furnace, etc.) _____

What precautions do you take for perceived allergy problems? (pillow covers, air cleaners, etc.) _____

DIETS

List foods that give you problems and describe the problems _____

_____

List any food additives that cause you problems (MSG, citric acid, food colorings...) _____

List any foods you avoid and tell why _____

_____

Are you on a special diet? ❒ No ❒Yes-Describe _____

Do you crave or binge on any foods? ❒ No ❒Yes-Describe _____

WOMEN: Do you have premenstrual food cravings? ❒ No ❒Yes-Describe _____

How many meals do you eat each week at: ___ home; ___ fast food restaurants; ___ other restaurants; ___ school; ___ pack/eat elsewhere

What foods do you eat on a typical day for:

Breakfast _____

Lunch _____

Dinner _____

What are your favorite three everyday foods? 1) _____ 2) _____ 3) _____

Do you consider yourself a sugar lover? ❒ No ❒ Yes Are you a vegetarian? ❒ No ❒ Yes

Circle the number of servings you eat each *week* from these categories:

Wheat products a (bread, pasta, pizza, cookies, breakfast cereals...)	1	2	3	4	5	6	7	8+
Corn products (popcorn, lunch meat, chips/tacos, cereals...)	1	2	3	4	5	6	7	8+
Other grains (rice, oats, oatmeal...)	1	2	3	4	5	6	7	8+
Dairy products (milk, cheese, yogurt, ice cream, butter...)	1	2	3	4	5	6	7	8+
Yeast (mushrooms, vinegar, salad dressing, soy sauce, raising, catsup, mustard...)	1	2	3	4	5	6	7	8+
Red meats (beef, hamburger, steak, pork, ham, bacon, sausage...)	1	2	3	4	5	6	7	8+
Other proteins (chicken, turkey, fish, seafood, hot dogs...)	1	2	3	4	5	6	7	8+
Eggs (of any kind; also products containing eggs like mayonnaise...)	1	2	3	4	5	6	7	8+
Fruits (apples, bananas, oragnes, pears, melon, grapes, grapefruit, tomatoes...)	1	2	3	4	5	6	7	8+
Vegetables (broccoli, beans, cabbage...)	1	2	3	4	5	6	7	8+
Peanut products (including peanut butter) or soy products (tofu, soy sauce...)	1	2	3	4	5	6	7	8+
Snack foods (potato chips, nuts other than peanuts, chocolate, candy, sugar substitute...)	1	2	3	4	5	6	7	8+
Beverages (coffee, tea, soda pop, diet soda...)	1	2	3	4	5	6	7	8+

ADDITIONAL COMMENTS

Please include any other information that would be useful in understanding this patient's history: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PEDIATRIC PATIENT INFORMATION

Were there problems during the child's ❒ prenatal period ❒ delivery ❒ postnatal period If yes, explain _____

_____

Did the child have colic as a baby? ❒ No ❒ Yes Is the child now on a full diet? ❒ No ❒ Yes

Was the child breasfed exclusively? ❒ No ❒ Yes-How many months?____ Did the child's mother drink milk while nursing the child? ❒ No ❒ Yes

Was the child fed formula? ❒ No ❒ Yes-Explain any problems tolerating formula: _____

How old was the child when supplemental feeding was begun? _____ months How old when solid foods were begun? _____ months

Were/are there foods that bother the child: ❒ No ❒ Yes-Explain _____

_____

Has the child's physical development been normal? ❒ No ❒ Yes Current height _____ feet _____inches (percentile of normal _____)

Current weight _____ pounds (percentile of normal _____)

At what age (month

Are the child's immunizations current? ❒ Yes ❒ No-Explain _____

How many infections has the child had in the last three months? _____ the last year? _____

Does the child have any chronic or recurring infections? ❒ No ❒ Yes-Explain _____

List any unusual or serious infections the child has ever had (meningitis, pneumonia...) _____

Is the child's school performance normal? ❒ No ❒ Yes-Explain issues (learning, behavioral, special education...) _____

_____

Please explain any abnormalities or delays in these areas of development:

Large motor skills (running, climbing, swimming) _____

Small motor skills (coloring, cutting, handwriting) _____

Hearing _____

Vision _____

Taste _____

Smell _____

Speech _____

Bladder/bowel control _____