SAN FRANCISCO ENT and ALLERGY

General Questionnaire: (Check all that apply) **Date:** ________________

Patient Name:___________________________ **Age:**____ **DOB:** ____________ **Gender: M F**
Occupation:_____________________________ **Employer:**_________________ **Retired: Y N**

Who/How referred by: PCP☐ **YELP** ☐ **Google**☐ **Friend**☐ **Ins co.**☐ **other**:____________
Name of PCP/ Referral Dr/NP/PA:____

MAIN REASON(S) for today's visit:
____
____

Length of time:____
Medications: (List all medications you take regularly, prescription and over-the-counter):
____
____

Allergies to any medications: ____
Medical History (check only positives) ……. Do you have:

__Diabetes
__High blood pressure
__Heart disease__stroke
Lung disease
__ asthma
__ emphysema
__ bronchitis
__ COPD
Eyes
__ glaucoma
__ cataracts
Neurological
__ Dizzyness/vertigo
__ Migraine/headache

Stomach problems
__ ulcer
__ reflux (GERD)__
Thyroid disorders
__ low thyroid
__ high thyroid
Psychiatric
__ depression
__ anxiety
__ seizures
Nasal / Eye allergy
__seasonal hayfever
mth J F M A M J J A S O
__ all year

Immunologic
__ lupus
__ rheumatoid arthritis
__ immune deficiencies
__ HIV
Muscle/skeletal
__ arthritis
__ gout
__ neck or back injury
Urologic
__ kidney stones
__ prostate

Past allergy skin tests: Y N when ___yrs ago **Past Allergy shots: Y N** when___ yrs ago
Past Surgical History:
__ **Sinus** surgery - when _______________ __ **Nasal** surgery – when____________________
__ **Other** ____

Environmental Exposures: (check as applies to you)
Home: Do you have a pet or care for animals.… Y / N List types ____________________
Are you regularly exposed : _ to second hand smoke…..Y / N **--** to chemicals…… Y / N
___ Apt. ____house ____carpeted ____hard wood floors ____ down bedding and pillows
Work: ___carpeted____air conditioning___closed building___pets

Social History:
Where did you grow up____________________ How long in the Bay Area _____ yrs
Alcohol Use: __ Never __ Several times a week __ Occasionally __ Daily
Tobacco Use: __ Use now __ Never used __ Quit (how long?____ Number years used____
Type: __ cigarettes _ cigars __ chew tobacco ___other Daily amount _____
Pregnant Y N

Family Medical History: (Check only if mother, father, siblings, or children have condition)
___ diabetes ___ high blood pressure ___ asthma ___ allergies ___eczyma ____ early hearing loss___
Other____

Symptoms bothering you (check all that apply in the *last 6 months or longer*)

Ears ☐ None
- __ Hearing loss
- __ Earache
- __ Ear drainage
- __ Ringing in ears
- __ Itchying
- __ Popping

Nose/Sinus ☐ None
- __ Nasal drainage
  - __ discolored
  - __ clear
- __ Nasal itching
- __ Nasal blockage
- __ Frequent sneezing
- __ Altered sense of smell
- __ Frequent nose bleeds
- __ Snoring
- __ Frequent sinus infections
- __ Sinus pressure/pain

Throat ☐ None
- __ Voice change/hoarseness
- __ Frequent sore throats
- __ Sores in mouth
- __ Post nasal drip
- __ mouth/lip itchy-swelling
- __ teeth grinding

Chest ☐ None
- __ Frequent cough
- __ Night cough only
- __ Shortness of breath
- __ Wheezing
- __ Tightness
- __ Mucus
- __ Exercise wheezing

Neurological ☐ None
- __ Frequent headaches
- __ Light headedness / dizziness
- __ Migraines

Eyes ☐ None
- __ Itchy
- __ Burning
- __ Redness
- __ Watery
- __ Dry
- __ Swelling

Skin ☐ None
- __ Rash / itching __local__general
- __ Hives (urticaria)
- __ Mouth/lip swelling
- __ Eczyma
- __ Redness

Gastrointenstinal ☐ None
- __ Heartburn
- __ Frequent burping
- __ Difficulty swallowing
- __ Feels like something stuck in throat
- __ Vomitting / Diarrhoa
- __ bloating, gas

Immunologic / Allergies ☐ None
- ___Bad reaction to foods:
  - ___dairy___eggs___wheat___soy
  - ___seafood/shellfish___fish
  - ___peanuts___nuts__________
- ___Bad reaction to___ insect bites
  - ___bees, wasps etc

Constitutional Symptoms ☐ None
- __ Unexplained weight change
- __ Frequent fever
- __ Frequent fatigue

Psychiatric ☐ None
- __ Fatigue
- __ Memory loss or confusion
- __ Excessive daytime sleepiness
- __ Trouble sleeping
- __ Anxiety