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: ____________________

ADD ADDITIONAL INFORMATION HERE

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 ____________________