The Corvallis Clinic™

ALLERGY HEALTH QUESTIONNAIRE

The following information will help your physician in reviewing your personal health, family history, and your current health habits. This will be kept in strict confidence and made part of the medical record. **Please give it to your physician at the time of your appointment.** Thank you for your consideration.

Last Name: ________________ First Name: ________________

Date of Birth: ________________ Home Phone Number: ________________

Social History

Place of Birth: ________________

Occupation: ________________

Briefly list current symptoms/complaints: ________________

Personal History

Check any of the illnesses/medical conditions that you have had.

- ❑ Asthma
- ❑ COPD
- ❑ High cholesterol
- ❑ Hay fever
- ❑ Pneumonia
- ❑ Anxiety
- ❑ Heart attack/angina
- ❑ Atopic Dermatitis/eczema
- ❑ High blood pressure
- ❑ Colon polyps
- ❑ Stroke
- ❑ Depression
- ❑ Seizures
- ❑ Stomach Ulcers
- ❑ Arthritis
- ❑ Hemorrhoids
- ❑ Irritable bowel
- ❑ Thyroid disease
- ❑ Hiatal hernia
- ❑ Kidney disease
- ❑ Diabetes
- ❑ Heartburn/acid reflux
- ❑ Psoriasis
- ❑ Headaches
- ❑ Osteoporosis
- ❑ Tuberculosis
- ❑ Cancer: ________________
- ❑ Other: ________________

List all surgeries/operations/hospitalizations:

Type	Year	Hospital/City/State

Medications (list your current prescriptions and over-the-counter medications)

Medication	Dose	How Often	Reason

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Allergies (food, medication, latex, insect stings; if so, please describe the reaction e.g. rash)

Habits

- ❑ Current smoker # packs per day ____________ Number of years ____________
- ❑ Former Smoker Quit Date ____________ Number of years ____________
- ❑ Never Smoked

Review of Systems (Please mark all that apply)

General:

- ❑ Fevers
- ❑ Weight Loss
- ❑ Fatigue

Head, Eyes, Ears, Nose, Throat, Lymph nodes:

- ❑ Nasal congestion/Stuffy nose
- ❑ Runny Nose
- ❑ Itchy Nose
- ❑ Sneezing
- ❑ Diminished Smell or Taste
- ❑ Itchy Throat or Mouth
- ❑ Sore Throat
- ❑ Post Nasal Drainage
- ❑ Throat Clearing
- ❑ Itchy Eyes
- ❑ Dry Eyes
- ❑ Red Eyes
- ❑ Swollen Eyelids
- ❑ Headache
- ❑ Itchy Ears
- ❑ Plugged Ears
- ❑ Ringing in Ears
- ❑ Diminished Hearing

Respiratory System:

- ❑ Shortness of breath
- ❑ Chest tightness
- ❑ Wheezing
- ❑ Cough

Gastrointestinal System;

- ❑ Abdominal pain
- ❑ Nausea
- ❑ Constipation
- ❑ Dysphagia (difficulty swallowing)
- ❑ Heartburn
- ❑ Hematochezia (red blood in bowel movements)
- ❑ Vomiting
- ❑ Diarrhea

Skin:

- ❑ Hives
- ❑ Swelling
- ❑ Eczema/Atopic Dermatitis
- ❑ Pruritus (itching)
- ❑ Other ____________

Family History

		Present health or cause of death
❑ Yes ❑ No Father living? Age ____		____________
❑ Yes ❑ No Mother living? Age ____		____________
How many brothers living? ____	Present health	____________
How many brother deceased? ____	Cause of death	____________
How many sisters living? ____	Present health	____________
How many sisters deceased? ____	Cause of death	____________
How many children living? ____	Present health	____________
How many children deceased? ____	Cause of death	____________

Do you know of any blood relatives who have or had the following? Please check and give relationship

- ❑ Asthma ____________
- ❑ Allergic Rhinitis/Hay Fever ____________
- ❑ Food Allergies ____________
- ❑ Atopic Dermatitis/Eczema ____________
- ❑ Thyroid Disease ____________
- ❑ Other ____________

Patient Signature ____________ Physician Signature ____________
Date ____________ Date ____________

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