

Location: _____

Patient Name _____

Date of Birth _____

Today's date _____

Referring Physician _____

Accompanied Today By _____

Other Family Members Who Are AAA Patients

In the boxes below - please mark all that apply.

*Reason(s) for
Visit*

- | | |
|--|---|
| <input type="checkbox"/> hay fever/nasal allergies | <input type="checkbox"/> ear problems |
| <input type="checkbox"/> rash/skin allergies | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> food allergy | <input type="checkbox"/> cough |
| <input type="checkbox"/> insect allergy | <input type="checkbox"/> shortness of breath/asthma |
| <input type="checkbox"/> eye problems | <input type="checkbox"/> chest infections |
| <input type="checkbox"/> headache/sinus problems | <input type="checkbox"/> Other: _____ |

First time problems
occurred? _____

(date)

When did this specific episode
start?

-
- 1 week ago
-
- 2 weeks ago
-
-
- 3 weeks ago
-
- 4 weeks ago
-
-
- more than a month ago
-
-
- unknown

How often does this problem
occur?

-
- everyday
-
- once per week
-
- 2 x per week
-
-
- monthly
-
- several times a year
-
- unpredictable

Which month(s) is it most
severe?

-
- Jan
-
- Feb
-
- March
-
- April
-
- May
-
- June
-
-
- July
-
- Aug
-
- Sept
-
- Oct
-
- Nov
-
- Dec
-
- All year

What time of day are the
symptoms worse?

-
- morning
-
- noon
-
- afternoon
-
- nighttime
-
- all the time

Are symptoms worse in
certain locations?

-
- home
-
- work
-
- outside
-
- indoors
-
- other: _____

Suspected cause of problems?

-
- trees
-
- weeds
-
- grass
-
- mold
-
- dust
-
- perfumes
-
- scents
-
- latex
-
-
- weather changes
-
- heat
-
- cold
-
- cats
-
- dogs
-
- stress
-
- smoke
-
-
- other (animals, foods, etc.): _____

How would you grade the degree
of your symptoms in the last 4
weeks?

-
- none
-
- mild
-
- moderate
-
- severe

How would you grade your
degree of symptoms today?

-
- none
-
- mild
-
- moderate
-
- severe

How long have you lived in the area?

_____ days week(s) year(s)

Moved from where?

Where did you grow up?

Patient Name _____

Date of Birth _____

Today's date _____

Review of Symptoms I

Please grade each of the following symptoms. **(Mark all that apply)**

	None	Mild	Moderate	Severe	
<i>Allergy/Sinus Symptoms</i>	Dark circles under eyes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Itchy/watery eyes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Red eyes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Swollen/puffy eyelids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ear infections:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ear pain/pressure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ear popping:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Congestion/blocked nose:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Decreased sense of smell:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nasal/sinus drainage:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nose bleeds:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Runny nose:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sinus infection:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sinus pressure/pain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sneezing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Snoring:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Snorting:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Post nasal/throat drainage:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Throat clearing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	None	Mild	Moderate	Severe	
<i>Neurological Symptoms</i>	Dizziness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fatigue/tired:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Headache:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lightheadedness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Problems sleeping:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Poor concentration:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sleep apnea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	None	Mild	Moderate	Severe	
<i>Asthma Symptoms</i>	Croup/laryngitis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chest infections:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chest tightness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cough:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cough productive of mucus:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Congestion:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shortness of breath (SOB):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SOB with exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SOB at night:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Wheezing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name

Date of Birth

Today's date

Review of Symptoms I - Continued

Please grade each of the following symptoms. **(Mark all that apply)**

	None	Mild	Moderate	Severe	
<i>Skin Symptoms</i>	Dry skin:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Eczema:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hives:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Itchy skin:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rash:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Skin swelling:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	None	Mild	Moderate	Severe	
<i>Gastrointestinal Symptoms</i>	Constipation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Diarrhea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heartburn/Indigestion/Reflux:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nausea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Vomiting:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>Other:</i>	
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Review of Symptoms II

(Mark all that apply)

<i>General:</i>	<input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> night sweats <input type="checkbox"/> weight loss <input type="checkbox"/> weight gain
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<i>Ears:</i>	<input type="checkbox"/> drainage <input type="checkbox"/> hearing loss <input type="checkbox"/> rupture of eardrum
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<i>Eyes:</i>	<input type="checkbox"/> burning <input type="checkbox"/> dry
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<i>Mouth:</i>	<input type="checkbox"/> bad breath <input type="checkbox"/> gum problems <input type="checkbox"/> lip swelling <input type="checkbox"/> tongue swelling <input type="checkbox"/> pain in teeth <input type="checkbox"/> teeth grinding <input type="checkbox"/> mouth itching <input type="checkbox"/> mouth ulcers
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<i>Throat:</i>	<input type="checkbox"/> difficulty swallowing <input type="checkbox"/> swelling <input type="checkbox"/> loss of voice
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<i>Chest:</i>	<input type="checkbox"/> chest pain <input type="checkbox"/> heaviness/pressure <input type="checkbox"/> heart palpitations
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<i>Urinary:</i>	<input type="checkbox"/> excessive urination <input type="checkbox"/> excessive thirst <input type="checkbox"/> pain/burning with urination <input type="checkbox"/> difficulty with urination
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<i>Extremities:</i>	<input type="checkbox"/> swollen joints <input type="checkbox"/> painful joints <input type="checkbox"/> athletes foot/nail fungus
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<i>Neurological:</i>	<input type="checkbox"/> anxiety <input type="checkbox"/> stress <input type="checkbox"/> depression <input type="checkbox"/> numbness/tingling <input type="checkbox"/> tremors <input type="checkbox"/> developmental/growth delay <input type="checkbox"/> heat or cold intolerance
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<i>Other:</i>	
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New Patient Questionnaire - Page 4

Patient Name

Date of Birth

Today's date

Social History

Occupation: n/a student hourly wage commission salary retired

Type of work: _____

Hobbies:

**Tobacco use/
exposure?**

Current everyday smoker Smoker, current status unknown Former smoker
 Current someday (social) smoker Never smoked Unknown if ever smoked

**If Current or
Former Smoker:**

Type: **Chewing** **Cigars** **Cigarettes** **Pipe** **Smokeless** **Snuff**
Packs/Units per Day _____ Years Used _____
Ever tried to quit? Y N Year Quit _____

Passive/Second hand smoke exposure? Yes No

Who/Where: _____

Do you drink alcohol? Yes No

Recreational drug use? Yes No

Do you have any HIV risk factors? Yes No Not sure

Family History

Race?

American Indian/Alaskan Native Asian Black Caucasian/White Hispanic
 More than one race Native Hawaiian/Other Pacific Islander Other Unknown/Not Reported

Ethnicity?

Hispanic or Latino Not Hispanic or Latino Unknown/Not Reported

Preferred Language?

Are there any family disputes/divorce situations that may make patient care more difficult? Yes No

(Mark any family members who have experienced any of the listed conditions)

	Father	Mother	Brothers	Sisters	Children	Others
Allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:						

Patient Name _____

Date of Birth _____

Today's date _____

Medical History

Please mark all that describe your current or past medical problems.

- | | | |
|--|---|--|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> reflux | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> hiatal hernia | <input type="checkbox"/> kidney problems |
| <input type="checkbox"/> stroke | <input type="checkbox"/> diabetes | <input type="checkbox"/> chronic infections |
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> emphysema | <input type="checkbox"/> skin problems |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> lupus/other | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> depression | <input type="checkbox"/> autoimmune disease | <input type="checkbox"/> bleeding problems |
| <input type="checkbox"/> bipolar | <input type="checkbox"/> gout | <input type="checkbox"/> osteoporosis/osteopenia |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> arthritis | |
| | <input type="checkbox"/> fibromyalgia | |

Please list all previous hospitalizations/surgeries/prosthetics devices (artificial limbs).

Description

Year

Other:

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Street

City

State

Zip

Pharmacy Phone #: _____

Pharmacy Fax #: _____

Prescription Type:

90 day mail in

Local

Mail & Local

