Charles H. Song, MD
Allergy, Asthma, and Immunology

PATIENT QUESTIONAIRE

PLEASE FILL IN OR CIRCLE.
Patient Name____________ Date of Birth_____________ Today's Date_______________
Referred by______________ Primary doctor___________

Do you have any **drug allergies?** Please list drugs and reaction.
____

Reason for Today's Visit____
____
____
____
____

When did it start ?_________________________ Worst season? Spring Summer Fall Winter
When is the worst time ? Morning, Afternoon, Evening, Night

Please circle the symptoms you find troublesome:

Lungs	Upper Respiratory	Skin	GI	Other
Wheezing	Itchy nose, mouth, eye	Hives	Weight problem	Dizziness
Asthma	Stuffy nose	Rash	Nausea	Anaphylaxis
Shortness of breath	Runny nose	Eczema	Vomitting	Fatigue
Chest tightness	Sneezing	Dryness	Diarrhea	Exercise Intolerance
Cough	Snoring	Itching	Heartburn	Please describe others.
Phlegm	Mouth breathing	Infections	Stomach ache	
Pneumonia	Sore itchy throat	Psoriasis		
	Sinus Pain			
	Sinus/nose surgery			
	Hearing loss			
	Loss of smell, taste			
	Sleep problems			

Are your symptoms brought on by:

Outdoor	Indoor	Foods	Drugs	Contact	Other
Temp change	Dust	Milk	Aspirin	Wool	Emotion
Wind	Perfume	Seafood	Penicillin	Cosmetics	Laughing
Weather	Animal	Nuts__________	Sulfa________		Exercise
Pollens	Smoke	Others-Name it	Other -Name it		Colds/Flu
Smog	Mold				
	Work place				
	Hobbies				

Who was your previous allergist? ___________________

Skin Test before? Yes____No____ When___________________
Allergy blood test before ? Yes____No____ When___________________
Allergy Shots Before? Yes____No____ When___________________
Allergy Shots Helpful? Yes____No____

Circle all **medications** you are taking. * - Check if the medicine is helpful.

Asthma	*	**Rhinitis/Allergy**	*	**Other**	*
Flovent/Pulmicort		Allegra/Claritin/Zyrtec			
Vanceril/Azmacort/Aerobid		Benadryl/Atarax/Nolahist			
Advair /Foradil		Entex / Sudafe			
Albuterol/Ventolin/Proventil		Vancenase/Becanse			
Serevent		Rhinocort			
Intal/Nedocromil		Nasonex			
Atrovent/Comivent		Nasalcrom			
Singular/Accolat/Zyflo					
Prednisone/Medral					

TURN TO THE BACK PAGE

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For **asthma patients only:** Do you use a spacer ? Yes____, No____
Do you use peak flow meter? Yes___ No___, What is the range of the flow rate?____

Environmental/Social History: Fill in or Circle.
Occupation________________________ Hobbies______________________________
Lives in House or Apartment. Carpet, Wooden floor, Linolium, Forced air heating
Do you have or frequently exposed any **pets** ? Yes/No. What type?_________________
Do you or anyone **smoke** in your home? Yes/No. Who?______, How many Packs/day_______
Do you drink **alcohol**? Yes/No. Type/Frequency_______________________
Do you miss work/school due to illness? ____days/month
Any learning/behavior problems at school? What kind? ___________________________

Family History: Please Check.

	Father	Mother	Children	sibling	Father's Parents	Mother's Parents
Asthma						
Hay fever						
Eczema						
Food allergy						
Sinus problem						
migraine						

Past Medical History

During childhood, which are allergic diseases did you suffer. Please circle. Asthma, Hay fever, Eczema

Have you ever been **hospitalized** or had **surgery?**
Date:______ Reason_____________________ Date:______ Reason_____________________
Date:______ Reason_____________________ Date:______ Reason_____________________

Dietary History only for children:
Breast Fed? How long________, Formula: Milk formula, Soy formula, Hypoallergenic formula
Baby foods : What age? ______ Solid food: What age?_______
Food intolerance: what kind? ____

Review of System

PART OF BODY/SYSTEM	PROBLEMS	TREATMENT IF ANY
Eyes		
Ears, Nose, Throat		
Chest and Lungs		
Heart and Blood Pressure		
Digestive		
Urinary		
Menstrual/Prostate		
Nervous System		
Joint and Muscles		
Skin		
Infection such as TB or HIV		
Other		

MD Review____________________ Date:__________________