COLORADO ENT & ALLERGY
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ALLERGY - NEW PATIENT QUESTIONNAIRE

PATIENT NAME: _____ **DOB:** _____

ENVIRONMENT:

Please Circle conditions that apply to the home: ☐House ☐Apartment ☐Mobile Home ☐Farm

What year was the home built? _____ Does the home have mold or water damage? ☐Yes ☐No

Please select items found in Patient's bedroom: ☐Carpeting ☐Hardwood/Laminate Flooring ☐HEPA Filter ☐Feather Pillows ☐Down Comforter

Please circle:

Does the home have: ☐A/C (Central Window) ☐Humidifier ☐Air Cleaner ☐Swamp Cooler

Does the home have pets? ☐Dog ☐Cat ☐Bird ☐Hamster ☐Horse ☐No Pets ☐Other: _____

Do any family members smoke? ☐Yes ☐No If yes, who smokes? _____

Does the Patient smoke? ☐Yes ☐No If yes, how many packs a day? _____

Has the Patient ever smoked? ☐Yes ☐No If yes, how many years did the Patient smoke? _____

Recreational drug use? ☐Yes ☐No Alcohol intake: ☐Never ☐Occasionally ☐Frequently ☐Daily

DIET: Are foods suspected to cause symptoms? ☐Yes ☐No

Describe any reactions to foods: _____

Currently on a special diet? ☐Yes ☐No Describe: _____

IMMUNIZATIONS: Up to date? ☐Yes ☐No Describe any reactions: _____

List all previous surgeries including any implants (knee, hip, other): _____

DOES THE PATIENT HAVE ANY OF THE FOLLOWING?

CONSTITUTIONAL (circle one)

Chronic Fatigue	☐Yes ☐No
Chronic Fever	☐Yes ☐No

EYES

Itchy Eyes	☐Yes ☐No
Red Eyes	☐Yes ☐No
Eye Drainage	☐Yes ☐No

EARS

Ear Infections	☐Yes ☐No
Ear Pain	☐Yes ☐No

NOSE

Nasal Congestion	☐Yes ☐No
Nasal Drainage	☐Yes ☐No
Post-Nasal Drip	☐Yes ☐No
Reduced Smell	☐Yes ☐No
Sinus Pressure	☐Yes ☐No
Sneezing	☐Yes ☐No
Itchy Nose	☐Yes ☐No

THROAT

Itchy Throat	☐Yes ☐No
Hoarse Throat	☐Yes ☐No
Throat Clearing	☐Yes ☐No

RESPIRATORY

Cough	☐Yes ☐No
Wheezing	☐Yes ☐No
Shortness of Breath	☐Yes ☐No
Chest Tightness	☐Yes ☐No

CARDIOLOGY

Chest Pain	☐Yes ☐No

GASTROENTEROLOGY

Abdominal Pain	☐Yes ☐No
Acid Reflux	☐Yes ☐No
Vomiting	☐Yes ☐No

SKIN

Rashes	☐Yes ☐No
Itchy Skin	☐Yes ☐No

PSYCH

Anxiety	☐Yes ☐No
Depression	☐Yes ☐No

NEUROLOGICAL

Headache	☐Yes ☐No

FAMILY HISTORY

Asthma: (circle one)
☐Mom ☐Dad ☐Siblings ☐Children

Seasonal or Pet Allergy:
☐Mom ☐Dad ☐Siblings ☐Children

Food Allergy:
☐Mom ☐Dad ☐Siblings ☐Children

Eczema:
☐Mom ☐Dad ☐Siblings ☐Children