

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.

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 _____

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 _____

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.) _____

Foods

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, oranges, 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 3456 7 8+

Snack foods (potato chips, nuts other than peanuts, chocolate, candy, sugar substitute...) 1 2 3456 7 8+

Beverages (coffee, tea, soda pop, diet soda...) 1 2 3456 7 8+

Additional Information

Please include any other information that would be useful in understanding this patient's history:

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 breastfed 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 _____)

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 _____