PATIENT QUESTIONNAIRE

Anthony Nguyen, DO
Allergy and Immunology
55 W. Tietan St.
Walla Walla, WA 99362
Phone: (509)525-3720 ext 1604/ Fax: (509)522-1581

MRN ___________________________

Appointment Date ___________________________

☐NEW ☐RETURN
FILL OUT CHANGES ONLY

PLEASE PRINT (Black Ink)
NAME____ Date of Birth________________________ Age________
Home Phone ____ Cell Phone ______________________________________

If Minor: Father's Name _________________________________ Mother's Name ___________________________________
Referred by ____☐Self-referral
Primary Care Physician __________________________________ Occupation:_____________________________________
Ethnicity___________________________ Primary Language________________________ Interpreter Needed ☐Yes ☐No
Student? Grade________ Sports ☐Yes ☐No Type_______________________________ Currently in Daycare ☐Yes ☐No

WHAT IS YOUR CHIEF COMPLAINT:____
PHARMACY name and location: ____

☐Asthma/Respiratory Symptoms
Onset_____________________Duration _______________ Triggers ____
Present medications____
Past medications____

☐Food Allergy/Food related symptoms
Onset__________________________________ Trigger____
Emergency Dept Visit____ Epinephrine Prescribed ☐Yes ☐No

☐Rhinitis/Nasal Symptoms
Onset_____________________Duration ________________ Triggers ____
Present medications:____
Past medications:____

☐Conjunctivitis/Eye symptoms
Onset_____________________Duration ________________ Triggers ____
Present medications:____
Past medications:____

☐Eczema/Skin rash
Onset_____________________Duration ________________ Triggers ____
Present medications:____
Past medications:____

☐Venom allergy/Insect Sting symptoms
Onset_________________________________ Trigger____
Emergency Dept Visit____ Epinephrine Prescribed ☐Yes ☐No

☐Autoimmune/Recurrent infections
Onset______________________________ Frequency ____

☐Penicillin Allergy ☐ **Medication Allergy** ____

Previous allergy skin tests, blood tests, or allergy shots
____
____

Non-Allergic problems
☐Hypertension Medications____
☐Diabetes Medications____
☐Thyroid Medications____
☐Other ____

Pregnant ☐Yes ☐No

Name: ____Date of Birth:__________________ MRN_______________

Past Medical History/Hospitalizations related to Allergy/Respiratory____
____
____

Pediatric History
☐Preterm (up to 37 weeks) ☐Full Term(37 to 41 weeks) Birth weight_______________
☐NICU Duration_______________ Reason____
Normal Growth & Development ☐Yes ☐No explain____
☐Adopted

Past Surgical History related to Chest/Heart/Ears/Nose/Throat
____
____
____

Immunizations/Date received ☐DTaP _________ ☐Influenza __________ ☐Pneumonia ___________☐Other___________

Please check any symptoms that you have
General Health ☐No problems ☐Fever ☐Chills ☐Feeling poorly ☐Fatigue ☐Weight gain ☐Weight loss
Eyes ☐No problems ☐Eye pain ☐Red eyes ☐Blurred vision ☐Eye discharge ☐Dry eyes ☐Itchy eyes
Ears/Nose/Throat ☐No problems ☐Earache ☐Loss of hearing ☐Jaw pain ☐Ringing of ears ☐Dental problems ☐Hoarseness
Heart ☐No problems ☐Chest pain/pressure ☐ Palpitations ☐Irregular heartbeat ☐Fainting ☐Leg pain with walking ☐Leg swelling
Respiratory ☐No problems ☐Shortness of breath ☐Wheezing ☐Productive cough ☐Continual dry cough ☐Dyspnea on exertion ☐Snoring
Digestive ☐No problems ☐Swallowing trouble ☐Bloating ☐Abdominal pain ☐Vomiting ☐Constipation ☐Diarrhea ☐Heartburn ☐Blood in stools
Musculoskeletal ☐No problems ☐Weakness ☐Joint stiffness ☐Joint swelling ☐Joint pain
Skin ☐No problems ☐Itching ☐Rash ☐Dry skin ☐Skin problems
Neurological ☐No problems ☐Confused ☐Seizures ☐Dizziness ☐Fainting ☐Headaches ☐Migraines
Mental Health ☐No problems ☐Memory problems ☐Stress ☐Anxiety ☐Depression
Hematological ☐No problems ☐Easy bleeding ☐Easy bruising ☐Anemia ☐Low platelets

Family History of:
Allergies ☐Yes ☐No List relation ____
Asthma ☐Yes ☐No List relation ____
Autoimmune disorder ☐Yes ☐No List relation ____
Recurrent Infections ☐Yes ☐No List relation ____

Social History	**YES**	**NO**	
Alcohol consumption	☐	☐	______drinks per week
Smoking currently	☐	☐	For _____ years _____ ppd
Smoking in past	☐	☐	For _____ years _____ ppd, quit ________ years/months ago
Chewing tobacco	☐	☐	For _____ years
Electronic Cigarettes (Vaping)	☐	☐	
Marijuana use	☐	☐	

Environmental History
Pets ☐Cat (indoor/in bedroom/outdoor) ☐Dog (indoor/in bedroom/outdoor) ☐Other(list)_____________________
Carpeting ☐**Yes** ☐No
Strong scents in home (candles, air fresheners, etc) ☐**Yes** ☐No
Smoker in home ☐**Yes** ☐No whom___________________________________
Dust mite encasings Pillow ☐**Yes** ☐No Mattress ☐**Yes** ☐No