Advanced Allergy, Asthma & Sinusitis P.C.
30 East 40th Street
New York, NY 10016
212.679.1200

PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: ______________________________________ HEIGHT:________ WEIGHT: ________

REVIEW OF SYSTEMS - CHECK ALL THAT APPLY:

Head & Neck
___ Eye Disease
___ Double vision
___ Blurred vision
___ Prior Ear Surgery
___ Ear Ache
___ Hearing loss
___ Dizziness
___ Ringing in ears
___ Nasal Obstruction
___ Nosebleeds
___ Nasal Discharge
___ Altered sense of smell
___ Sinusitis
___ Nasal Polyps
___ Snoring
___ Excessive sleepiness
___ Facial pain
___ Pain with chewing
___ Recent dental work
___ Mouth sores
___ Lumps in the neck
___ Allergies

Respiratory System
___ Hoarseness
___ Chronic cough
___ Throat clearing
___ Heart Burn
___ Regurgitation
___ Spitting up blood
___ Shortness of breath
___ Wheezing
___ Asthma
___ Chronic bronchitis
___ Chest Pain
___ Emphysema
___ Tuberculosis
___ Lung cancer

Neurologic
___ Headaches
___ Head injury
___ Numbness or tingling
___ Transient black-outs
___ Transient vision loss
___ Seizures
___ Strokes

General
___ Night Sweats
___ Fevers
___ Skin diseases
___ Arthritis
___ Bleeding Disorder
___ Easy Bruisability
___ HIV infection or AIDS
___ Psychiatric Diseases

Gastrointestinal
___ Difficult swallowing
___ Pain on swallowing
___ Diarrhea
___ Constipation
___ Jaundice
___ Liver Disease
___ Hepatitis
___ Kidney Disease
___ Bloody stools
___ Diverticulosis
___ Gall bladder disease
___ Heartburn or ulcers

Cardiovascular
___ Hypertension
___ Heart disease
___ Angina
___ Swelling of the ankles
___ Heart surgery
___ Angioplasty
___ Pacemaker
___ Anemia

Endocrine
___ Diabetes
___ Heat/cold intolerance
___ Thyroid imbalance
___ Menstrual disorders

Urologic
___ Difficulty on urination
___ Frequent urination
___ Blood in the urine
___ Prostate problems

Other
____

Past and present medical problems:
____
____
____
____
____
____

Previous surgeries and dates (month/year)
________________________ (/)
________________________ (/)
________________________ (/)
________________________ (/)
________________________ (/)
________________________ (/)

List all current medications and dosages (including OTC):
____
____
____
____
____
____

Do you smoke?
____ Yes ____ No
If yes, how much?
____

Do you drink alcohol?
____ Yes ____ No
If yes, how much?
____

Any other information for Dr.?
____
____
____

Please list all allergies:
(medications, inhalants, foods, contact allergies) ________________________

Reason for today's visit: ________________________

Patient Signature ________________________ Date ____________

Physician Signature ________________________ Date ____________