IMMUNOe HEALTH CENTERS
Excellence in Immune Health

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Patient History Questionnaire

Today's Date _____

Name _____ Date of Birth _____

What are the symptoms which bother you the most? _____

_____

_____

_____

Allergy History

Have you been diagnosed with allergies? *(if yes, provide aprox date)*	☐ No ☐ Yes	____/____/_____		
Do you experience any of the following symptoms? *(check all that apply)*	☐ Runny Nose	☐ Congestion	☐ Sneezing	☐ Itchy Eyes
	☐ Watery Eyes	☐ Snoring		
When do your symptoms seem to be the worst? *(check all that apply)*	☐ Spring Months	☐ Fall Months	☐ Year-Round	☐ Animal Contact
	☐ Dust Exposure			
Have you ever had either of the following? *(if yes, provide aprox date/by whom)*	☐ No ☐ Yes	Percutaneous Allergy Testing (Skin)		____/____/_____
	Testing Completed By: _____			
	☐ No ☐ Yes	Allergy Blood Testing (RAST)		____/____/_____
	Testing Completed By: _____			
Have you ever been on allergy injections? *(if yes, provide aprox start/stop date)*	☐ No ☐ Yes	Start: ____/____/_____	Stop: ____/____/_____	
Have you tried any of the following medications? *(check all that apply)*	☐ Allegra	☐ Benadryl	☐ Claritin	☐ Zyrtec
Have you seen a ENT in the past? *(If yes, provide name/contact info)*	☐ No ☐ Yes	_____		

Respiratory History

Have you been diagnosed with asthma? *(if yes, provide aprox date)*	☐ No ☐ Yes	____/____/_____		
Have you been diagnosed with COPD? *(if yes, provide aprox date)*	☐ No ☐ Yes	____/____/_____		
Do you experience any of the following symptoms? *(if yes, ✓ additional)*	☐ No ☐ Yes	Cough **Worsens:**	☐ At Night	☐ Lying Down
			☐ w/ Cold Air	☐ w/ Exercise
	☐ No ☐ Yes	SOB **Worsens:**	☐ At Night	☐ Lying Down
			☐ w/ Exercise	
	☐ No ☐ Yes	Wheeze **Worsens:**	☐ At Night	☐ w/ Exercise
			☐ w/ Cold Air	☐ w/ Illness
Have you tried any of the following medications? *(check all that apply)*	☐ Advair	☐ Albuterol	☐ Asmanex	☐ Dulera
	☐ Flovent	☐ Pulmicort	☐ Symbicort	☐ Qvar
Have you seen a Pulmonologist in the past? *(If yes, provide name/contact info)*	☐ No ☐ Yes	_____		

Skin History

Do you experience any of the following symptoms? *(check all that apply)*	☐ Dermatitis	☐ Hives	☐ Dry Skin	☐ Itchy Skin
What seems to make your symptoms worsen? *(check all that apply)*	☐ Animal Contact	☐ Winter (Cold)	☐ Illness	
Do you ever experience the following? *(if yes, ✓additional)*	☐ No ☐ Yes	Skin Lesions	☐ Painful?	☐ Slow To Heal?
			☐ Comes/Goes?	☐ Chronic?
Have you tried any of the following medications? *(check all that apply)*	☐ Elidel	☐ Aclovate	☐ Triamcinalone	☐ Daily Lotion
Have you seen a Dermatologist in the past? *(If yes, provide name/contact info)*	☐ No ☐ Yes			

Gastrointestinal History

Have you been diagnosed with any of the following? *(if yes, provide aprox date)*	☐ No ☐ Yes	Candidiasis		____/____/_____
	☐ No ☐ Yes	Celiac Disease		____/____/_____
	☐ No ☐ Yes	Crohn's Disease		____/____/_____
	☐ No ☐ Yes	Gastroesophageal Reflux (GERD)		____/____/_____
	☐ No ☐ Yes	Irritable Bowel Syndrome (IBS)		____/____/_____
	☐ No ☐ Yes	Lactose Intolerance		____/____/_____
	☐ No ☐ Yes	Ulcerative Colitis		____/____/_____
Do you experience any of the following symptoms? *(check all that apply)*	☐ Diarrhea	☐ Constipation	☐ Heartburn	☐ Nausea
	☐ Vomiting			
Do you ever experience the following? *(if yes, ✓additional)*	☐ No ☐ Yes	Abdominal Pain	Sudden Onset?	☐ No ☐ Yes
	☐ No ☐ Yes	Abdominal Swelling	Sudden Onset?	☐ No ☐ Yes
Have you seen a GI Specialist in the past? *(If yes, provide name/contact info)*	☐ No ☐ Yes			

Food Allergy History

Have you been diagnosed with food allergies? *(if yes, list specific foods)*	☐ No ☐ Yes		
Do you experience any of the following symptoms? *(check all that apply)*	☐ Tightness In Throat	☐ Itching In Throat	
	☐ Difficulty Swallowing	☐ Swelling Of Tongue	
	☐ Swelling of Lips		
Have you tried to eliminate any foods from your diet? *(if yes, list specific foods)*	☐ No ☐ Yes		
Have you been administered Epinephrine in the past? *(due to reaction to food)*	☐ No ☐ Yes		

Miscellaneous Allergy History

Do you have an allergy to insect sting/bites?	☐ No ☐ Yes	
Do you have an allergy or sensitivity to latex?	☐ No ☐ Yes	
Do you have an allergy or sensitivity to medications? *(If yes, list medications)*	☐ No ☐ Yes	

Immune History

Have you been diagnosed with any of the following? *(if yes, provide aprox date)*	☐ No ☐ Yes	Autism	____/____/_____
	☐ No ☐ Yes	Cancer *(type)*: _____	____/____/_____
	☐ No ☐ Yes	Chronic Fatigue Syndrome	____/____/_____
	☐ No ☐ Yes	Developmental Delay	____/____/_____

	☐ No ☐ Yes	Fibromyalgia		____/____/_____

Immune History *(continued)*

	☐ No ☐ Yes	Hypothyroidism		____/____/_____
	☐ No ☐ Yes	Infectious Mononucleosis (EBV)		____/____/_____
	☐ No ☐ Yes	Lyme Disease		____/____/_____
	☐ No ☐ Yes	Multiple Sclerosis		____/____/_____
	☐ No ☐ Yes	PANDAS/PANS		____/____/_____
	Other *(inc. date)*:			

Do you experience any of the following symptoms? *(check all that apply)*	☐ Fatigue	☐ Memory Loss	☐ Lack Of Sleep	☐ Muscle Aches
	☐ Muscle Weakness		☐ Involuntary Movements (Tremors)	
	☐ Tingling In Extremities		☐ Numbness In Extremities	
	☐ Constant Ringing In Ears (Tinnitus)			
Do you experience any of the following joint symptoms? *(if yes, ✓ additional)*	☐ No ☐ Yes	Pain	**Where?** ☐ Only 1 Joint: _____	
			☐ > 1 Joint: _____	
			Severity? ☐ Getting Worse	☐ Chronic
	☐ No ☐ Yes	Swelling	**Where?** ☐ Only 1 Joint: _____	
			☐ > 1 Joint: _____	
			Severity? ☐ Occurs Suddenly	☐ Chronic
Do you have complaint of recurrent headache? *(if yes, ✓ additional)*	☐ No ☐ Yes		**Severity?** ☐ Mild	☐ Severe
			Duration? ☐ A Few Hours	☐ Lasts 1-3 Days
			Frequency? ☐ Daily	☐ Multiple/Wkly
			☐ Every Few Wks	
Have you ever had a 'Pneumococcal' vaccine? *(vaccine for pneumonia)*	☐ No ☐ Yes	Approximate Administration Date: ____/____/_____		
Approximate prescribed antibiotic courses per year?	_____ / Year	For: _____		
Approximate hospitalizations (for illness/symptoms) per year?	_____ / Year	For: _____		
Approximate ER visits (for illness/symptoms) per year?	_____ / Year	For: _____		
Have you seen a Rheumatologist in the past? *(If yes, provide name/contact info)*	☐ No ☐ Yes	_____		
Have you seen a Neurologist in the past? *(If yes, provide name/contact info)*	☐ No ☐ Yes	_____		

Infection History

Do you have a recurrent history of any of the following? *(If yes, estimate #/yr)*	☐ No ☐ Yes	Bronchopulmonary Infections	_____ / Year
	☐ No ☐ Yes	Cold Sores	_____ / Year
	☐ No ☐ Yes	Ear Infections	_____ / Year
	☐ No ☐ Yes	Gastrointestinal (GI) Infections	_____ / Year
	☐ No ☐ Yes	Oral Thrush Infections	_____ / Year
	☐ No ☐ Yes	Pneumonia	_____ / Year
	☐ No ☐ Yes	Sinus Infections	_____ / Year
	☐ No ☐ Yes	Skin Infections	_____ / Year
	☐ No ☐ Yes	Strep Infections	_____ / Year
	☐ No ☐ Yes	Respiratory Infections (Viral)	_____ / Year
	☐ No ☐ Yes	Urinary Tract (UTI) Infections	_____ / Year
	☐ No ☐ Yes	Yeast/Candida Infections	_____ / Year

Surgical History

Have you had any of the following surgeries/procedures? *(if yes, provide date)*	☐ No	☐ Yes	Adenoidectomy	____/____/_____
	☐ No	☐ Yes	Appendectomy	____/____/_____
	☐ No	☐ Yes	Breast Enlargement	____/____/_____
	☐ No	☐ Yes	Cholecystectomy	____/____/_____
	☐ No	☐ Yes	Intestinal Polyp Removal	____/____/_____
	☐ No	☐ Yes	Sinus Surgery	____/____/_____
	☐ No	☐ Yes	Stent	____/____/_____
	☐ No	☐ Yes	Tonsillectomy	____/____/_____
	Other *(inc. date)*:			

Diagnostic Testing History

Have you had any of the following diagnostic testing's? *(if yes, provide date)*	☐ No	☐ Yes	Chest Ct Scan	____/____/_____
	☐ No	☐ Yes	Chest X-Ray	____/____/_____
	☐ No	☐ Yes	Colonoscopy	____/____/_____
	☐ No	☐ Yes	Electromyography (EMG)	____/____/_____
	☐ No	☐ Yes	MRI Of Brain/Head	____/____/_____
	☐ No	☐ Yes	Sinus Ct Scan	____/____/_____
	☐ No	☐ Yes	Upper Endoscopy (EGD)	____/____/_____
	☐ No	☐ Yes	Upper GI (Barium Swallow)	____/____/_____

Social History

What is your occupation?				
What type of environment do you work in? *(check all that apply)*	☐ No	☐ Yes	Work in a recently renovated building	
	☐ No	☐ Yes	Work in building with sealed windows/insufficient airflow	
	☐ No	☐ Yes	Work requires exposure to extreme temperatures	
	Other:			

Do you consume alcohol? *(if yes, ✓additional)*	☐ No	☐ Yes	**Consumption:** ☐ Socially	☐ Daily Use
Do you use marijuana? *(if yes, ✓additional)*	☐ No	☐ Yes	**Consumption:** ☐ Socially	☐ By Prescription

Environmental History

What type of environment do you currently live in?	☐ House		☐ Apartment/Condominium		☐ Farm
Which of the following apply to your current home? *(check all that apply)*	Basement		☐ Finished?	☐ Unfinished?	☐ None
	Flooring		☐ Hardwood	☐ Carpet	☐ _____
	Pillows/Bedding		☐ Feather	☐ Cotton	☐ Synthetic
	Windows		☐ Open/Day	☐ Open/Night	☐ Open/Winter
		Treatments	☐ Drapes	☐ Blinds	☐ Shades
	Air Conditioning		☐ Central	☐ Window Unit	☐ None
Do you run a humidifier in your home or bedroom? *(if yes, ✓additional)*	☐ No	☐ Yes	☐ Cold Mist	☐ Warm Mist	
Do you run a air purifier in your home or bedroom? *(if yes, ✓additional)*	☐ No	☐ Yes	Does it have a HEPA filter?		☐ No ☐ Yes
Are you exposed to cigarette smoke in your home? *(if yes, ✓additional)*	☐ No	☐ Yes	☐ Second-Hand Exposure		☐ I Smoke
Do any of the following animals live in your home? *(if yes, ✓additional)*	Cat		☐ No ☐ Yes	Number Living In Home: _____	
	Dog		☐ No ☐ Yes	Number Living In Home: _____	

	Bird	☐ No	☐ Yes	Number Living In Home: _____		

Family History

Do you have a family history of any of the following? *(if yes, ✓ additional)*	☐ No	☐ Yes	Allergies	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Alzheimer's Dis.	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Anxiety	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Asthma	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Cancer	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Depression	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Diabetes	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Heart Disease	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Immune Disorder	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Lupus	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Osteoarthritis	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Renal Disorder	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Stroke	☐ Mom	☐ Dad	☐ _____
	☐ No	☐ Yes	Thyroid Disorder	☐ Mom	☐ Dad	☐ _____
	☐ Family History Unattainable: _____					

Please list any additional information you think may be pertinent/helpful to your consultation (i.e.: additional specialists seen, additional diagnosis, etc.):

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