CENTER FOR COUGH
MANDEL SHER, M.D.

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____.

INSTRUCTIONS: **Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your problem. Please bring this completed form to your first appointment.**

1. PROBLEMS: Have you ever had the following problems or conditions?

Yes	Check all items that apply	Age at onset	Severity Mild, Moderate or Severe	
	Skin:			
	Rashes			
	Eczema			
	Hives or swelling			
	Bruising			
	Infections:			
	Ear Infections			
	Throat Infections			
	Sinus Infections			
	Pneumonia			
	Bronchitis			
	Other infections			
	Eyes:			
	Watery, itching and/or redness			
	Dark circles			
	Dry eyes			
	Allergic reactions:			
	Food reactions			
	Drug reactions			
	Insect reactions			
	Latex Allergy			
	Metal Allergy			

2. MEDICATIONS: List all medications that you are currently taking (name, strength, number of times a day):

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

3. FOOD REACTIONS: Have you ever had any symptoms (rash, hay fever, vomiting, gas, cramps, diarrhea, colic as an infant) after the ingestion of any food, liquid, MSG, Sulfites, or food coloring? If yes please give details below.

FOOD	DATE	SYMPTOMS	Can food be eaten? Yes	No	DATE FOOD WAS LAST EATEN.

4. OTHER MEDICAL PROBLEMS: Have you ever been diagnosed with or had any of the following? Circle all that apply

Hearing Loss
Glaucoma
Glasses
Diabetes
Coughed up blood
Tuberculosis
Heart Trouble
High Blood Pressure
Hepatitis or Liver Trouble
Frequent Heartburn
Frequent Diarrhea
Frequent Constipation
Bedwetting
Arthritis
Fatigue
Kidney or Bladder Trouble
Disruptive Sleep
Fever
Chills / Sweats
Sensitivity to Sun
Poison Ivy
Poison Oak
Other:_____
_____

HEADACHES : Circle all that apply

Frequent headaches Pressure Unilateral Bilateral Visual Disturbances

Nausea Vomiting Severity _____ Triggers _____

5. SLEEPINESS SCALE: Are you sleepy during the day? If so complete the following using the following scale.

1 = Slight chance of dozing **2 =** Moderate chance of dozing **3 =** High chance of dozing

CHANCE OF DOZING	SITUATION OF DOZING / FALLING ASLEEP
_____	Sitting and reading?
_____	Watching television?
_____	Sitting inactively in a public place (such as a theater or meeting)?
_____	As a passenger in a car for an hour without a break?
_____	Lying down to rest in the afternoon when circumstances permit?
_____	Sitting and talking to someone?
_____	Sitting quietly after lunch without alcohol?
_____	In a car, while stopped for a few minutes in traffic?

6. WEIGHT: Weight now:_____ Weight one year ago:_____ Maximum weight: _____When?_____

7. IMMUNIZATIONS: Have you ever experienced any adverse reactions to any immunizations? List dates and reactions, if any.

Tetanus Booster_____ Influenza _____

Pneumovax_____ MMR _____

HIB_____ Prevnar_____

Other: _____

8. BIRTH HISTORY: Please complete the following:

Place of Birth:_____ Age of mother at birth:_____

Was pregnancy normal: ☐ Yes ☐ No If no, please specify reason: _____

_____

Was delivery by: ☐ C-Section ☐ Vaginal Patient was: ☐ Formula fed ☐ breast fed

In the first year of life were any of the following present? ☐ Colic ☐ Spit up a lot ☐ Rash ☐ Eczema

Was patient born with pets present in the home? ☐ Yes ☐ No (If Yes, please list): _____

9. HOSPITALIZATIONS: Please list any surgeries or medical conditions for which you have been hospitalized. (also list dates and doctors)

1. _____
2. _____
3. _____
4. _____
5. _____

10. RESIDENCE: List your past residents with your most recent first. List only city and state.

	City & State	How Long	Symptoms better	Symptoms worse	No Change
1.					
2.					
3.					

11. WORK ENVIRONMENT:

What type of work do you do? _____ Where are you employed?_____

Is your work environment: ☐carpeted ☐ tiled Are you exposed to chemicals or strong odors or anything that might aggravate your condition?

If yes, please specify: _____

Are you exposed to smoke? ☐ Yes ☐ No Are your symptoms worse at work? If yes please specify:_____

Have you missed work because of your condition? _____ How many days in the last year? _____

12. SCHOOL ENVIRONMENT:

What school do you attend? _____ Is your classroom: ☐ carpeted ☐ tiled

Is there a problem with mold or mildew? _____

Have you missed school because of your condition? _____ How many days in the last year? _____

Do you feel school performance has been affected? _____

13. MARITAL STATUS: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children:_____

14. FAMILY HISTORY: Do any members of your family have a history of any of the following?

	Yes	No	(If Yes): List Relationship
Asthma	☐	☐	
Allergies	☐	☐	
Hay Fever	☐	☐	
Eczema	☐	☐	
Hives	☐	☐	
Swelling	☐	☐	
Pneumonia	☐	☐	
Headaches	☐	☐	
Emphysema	☐	☐	

	Yes	No	(If Yes): List Relationship
Lung Disease	☐	☐	
Cystic Fibrosis	☐	☐	
Tuberculosis	☐	☐	
Thyroid Disease	☐	☐	
Glaucoma	☐	☐	
Diabetes	☐	☐	

Other: Please Specify_____

_____

15. ENVIRONMENTAL SURVEY:

Where do you live? ☐City ☐ Rural	Is the home: ☐ carpeted ☐ tiled Is bedroom: ☐ carpeted ☐ tiled
House construction (brick wood etc.):	How old is your _____pillow? _____Mattress?
Approximate age of house:	Is your pillow: ☐ feather ☐ foam rubber ☐ Dacron ☐ encased in plastic ☐ other:
Are any rooms damp or musty?	Is your mattress: ☐ innerspring ☐ foam rubber ☐ Waterbed ☐ encased in plastic ☐ other:
Type of air conditioning? (central, wall unit etc.):	Are your sheets washed in: ☐ cold ☐ warm ☐ hot water
Type of heating? (electric, gas, central, etc.)	Do you have any: ☐ Stuffed furniture ☐ Feather comforters ☐ stuffed animals
Do you have: ☐ Air Cleaner ☐ Air dehumidifier	Do you have pets? (List number and kind. dog, cats, birds, horses etc):
How often do you change/clean your air conditioner and air cleaner filters?	
Number of indoor plants in the home:	Do your pets spend time indoors?
What kind of grass, shrubs and trees are around the home? List:	Other:

16. SMOKING / ALCHOHOL / CAFFEINE USE:

Have you ever smoked? ☐Yes ☐ No If yes, how many years?_____ Do you presently smoke? ☐Yes ☐ No

If no, when did you stop_____ Average cigarettes per day at highest point?_____

If you still smoke, do you think you could stop? ☐Yes ☐ No Do you or family members smoke ☐ In the house ☐ In the car

Which other family members now smoke?_____

Do you drink alcohol ☐Yes ☐ No If yes, list type:_____

Average weekly consumption (times per week):_____

Any other Drug use? ☐Yes ☐ No If Yes, Explain:_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Name of person completing questionnaire (please print) Signature