South Bay Allergy & Asthma Group
A Medical Corporation

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(650) 966-8201

14981 National Ave., Ste. 3
Los Gatos, CA 95032
(408) 358-1771

www.sballergy.com

MEDICAL QUESTIONNAIRE

Todays' Date: _____

Patient Name: _____ **DOB:** _____ **Age:** _____

How were you referred to SBAAG? _____

Who is your Primary Doctor? (Name & Location) _____

What brings you to SBAAG? (Brief description) _____

Personal Information:

Gender: ☐ Female ☐ Male Place of Birth: _____

Race: ☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Other (Specify): _____

Occupation: _____ Employer Name: _____

Current Medication:

Please list ALL medications/supplements that you are currently taking (including all that were not prescribed by an MD).

Medication:	Dosage:	How Taken:	Frequency:	Date Started:	Taken For:

☐ Check here if list is continued on another page

Do you have a preferred **Pharmacy**? Name & Location / Phone Number: _____

_____

… more questions on reverse

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Patient Name: _____ Date of Birth: _____

Allergies:

Medications: ☐ No Known Drug allergies
☐ Penicillin ☐ Sulfa ☐ Other: _____
_____
☐ Check here if list is continued on another page

Foods: ☐ No known Food allergies
☐ Milk ☐ Egg ☐ Shellfish ☐ Wheat
☐ Peanut ☐ Other Foods: _____
_____

Environmental:

Check any that apply to your home environment:

☐ No Pets or Smoke Exposure
☐ Carpet? _____ Bedroom Living Area (circle all that apply)
☐ Air Purifier:_____
☐ Cat(s): How Many? _____ Inside Outside (circle one)
☐ Dog(s): How Many? _____ Inside Outside (circle one)
☐ Other Animals: _____ Inside Outside (circle one)
☐ Dusty: Yes No Medium (circle one)
☐ Humidifier? Yes No (circle one)
☐ Pillow: How Old? _____
☐ Blanket/Comforter: How Old? _____
☐ Mattress: How Old? _____
☐ Trees? Oak olive birch cedar walnut maple elm (circle all that apply)
☐ Trees (other): _____
☐ Length of time in the Bay Area? _____

Family:

Who in your family has had any of these symptoms and/or conditions, currently or in the past?

Allergic Rhinitis/"Hay fever":_____

Asthma: _____

Food Allergies: _____

Eczema: _____

Hives: _____

Sinus disease: _____

Immune deficiency: _____

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Patient Name: _____ Date of Birth: _____

Operations:

☐ None
☐ Yes, please list below:

What was operated:	What side was operated:	Date of operation:	Surgeon:
☐ Eye			
☐ Sinus, Septum or Nasal			
☐ Knee			
☐ Shoulder			
☐ Abdominal			
☐ Other (please list)			

Past Medical History:

☐ No significant past medical history
☐ Allergies
☐ Asthma
☐ Eczema
☐ Food allergies
☐ Hives (urticaria)
☐ Hypertension
☐ Heart
☐ Diabetes
☐ Thyroid disease
☐ High Cholesterol
☐ Other (please list):

_____ _____
_____ _____

Smoking Status:

☐ Never Smoked
☐ Former Smoker Last smoked? _____ How long did you smoke? _____
☐ Current Smoker How often do you smoke? _____ How long have you smoked? _____
☐ Secondhand smoke exposure? Yes No

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Patient Name: _____ Date of Birth: _____

Social History:

Are you/your child a student? ☐Yes ☐No What grade/level? _____

Is the patient in childcare (if applicable): ☐Yes ☐No

Alcohol: Do you drink alcohol?

- ☐ No (denies)
- ☐ Heavy
- ☐ Moderate (males: 2 drinks per day / females: 1 drink per day)
- ☐ Occasionally

Immunizations: Have you had a tuberculosis skin test (PPD)? ☐ Yes ☐ No If Yes, was it negative? ☐ Yes ☐ No

Date of test? _____

Do you have an annual flu vaccine? ☐ Yes ☐ No

Have you had a tetanus shot? ☐ Yes ☐ No If Yes, Date? _____

Have you had a pneumococcal vaccine (Pneumovax)? ☐ Yes ☐ No If Yes, Date?_____

Diagnostic Studies:

Have you had a Chest X-ray or Cat-Scan (CT)? _____

Which Study? ☐ X-Ray ☐ Cat-Scan (CT) When? _____

Where was it done? ☐ VRI ☐ Other: _____

Have you had a Sinus X-ray or Cat-Scan (CT)? _____

Which Study? ☐ X-Ray ☐ Cat-Scan (CT) When? _____

Where was it done? ☐ VRI ☐ Other: _____

Questionnaire Filled out by: ☐ Patient

☐ Parent: Father Mother Name:_____

☐ Other: Relation _____ Name:_____

Office use: Entered into system by: _____

If you have filled out this questionnaire prior to your appointment please return by fax or email -
fax to: 408-286-1744 OR email to: info.sbaag@gmail.com