Theodore J. Chu, MD, Allergy and Asthma, Inc.

PRACTICE LIMITED TO ALLERGIC DISEASES AND ASTHMA IN CHILDREN AND ADULTS

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MEDICAL QUESTIONNAIRE

Todays' Date: _____

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

How were you referred to TJCAAI? _____

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

What brings you to TJCAAI? (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

MEDICAL QUESTIONNAIRE

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: _____

MEDICAL QUESTIONNAIRE

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

MEDICAL QUESTIONNAIRE

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?_____

Have you been Vaccinated for COVID? ☐Yes ☐No If yes, Which one? ☐Pfizer ☐Moderna ☐J&J;

Date last dose? _____Was last dose was your ☐ 1st ☐ 2nd ☐ 3rd(Booster)?

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: (669)-242-7914