Patient name: _____ DOB: _____

Medical Questionnaire

Today's date: _____ Patient name: _____

DOB: _____ Age: _____

How were you referred to TJCAAI: _____

Primary doctor (name & location): _____

What brings you to TJCAAI? (Brief description): _____

Personal Information

Race: ▢ Asian ▢ Black ▢ Caucasian ▢ Hispanic ▢ Others (specify): _____

Gender: ▢ Female ▢ Male ▢ Nonbinary Place of birth: _____

Occupation: _____ Employer name: _____

Current Medication

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

Medication	Dosage	How taken	Frequency	Date started	Taken for

▢ Check here if list is continued on another page

Preferred pharmacy (name, location / phone number): _____

Allergies

Patient name: _____ DOB:

_____

Medications

☐ No known drug allergies ☐ Penicillin

☐ Sulfa ☐ Others: _____

_____

Food

☐ No known food allergies ☐ Milk ☐ Egg

☐ Shellfish ☐ Wheat ☐ Peanut ☐ Other food: _____

Environmental

Check all that apply to your home environment.

☐ No pets or smoke exposure

☐ Air purifier

☐ Humidifier

Dust level ☐ Low ☐ Medium ☐ High

Carpet in ☐ bedroom ☐ living area

Pillow(s). How old: _____

Blanket / comforter(s). How old: _____

Mattress. How old: _____

Cat(s). How many: ____ ☐ Inside ☐ Outside

Dog(s). How many: ___ ☐ Inside ☐ Outside

Other animal(s). How many: _____ ☐ Inside ☐ Outside

Trees. ☐ Birch ☐ Cedar ☐ Elm ☐ Oak ☐ Olive ☐ Maple ☐ Walnut ☐ Others: _____

_____

Length of time in the Bay Area: _____

Family history

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: _____

Patient name: _____ DOB:

_____

Operations

▢ None ▢ List all that applies:

What was operated	Which side was operated	Date of operation	Surgeon
Eye			
Sinus, septum, or nasal			
Knee			
Shoulder			
Abdominal			
Others (please list)			

Past Medical History

▢ No significant past medical history

▢ Allergies

▢ Asthma

▢ COVID infection. Date: _____

▢ Diabetes

▢ Eczema

▢ Food allergies

▢ High cholesterol

▢ Hives (urticaria)

▢ Heart condition

▢ Hypertension

▢ Thyroid disease

▢ Others (please list): _____

_____

Smoking History

▢ Never smoked

▢ Current smoker. How often? _____

How long have you smoked? _____

▢ Second-hand exposure?

▢ Former smoker. Date last smoked _____

How long did you smoke?

Patient name: _____ DOB:

_____

Social History

Is the patient a student? ▢ Yes ▢ No. Grade / level _____

Alcohol consumption: ▢ No ▢ Heavy ▢ Moderate (males: 2 drinks / day, females: 1 drink / day)
▢ Occasionally

Immunizations

Tuberculosis skin test (PPD). Result: ▢ Positive ▢ Negative. Date of test _____

▢ Annual flu vaccine

▢ Tetanus shot. Date of shot _____

▢ Pneumococcal vaccine (Pneumovax). Date of vaccine _____

COVID vaccine. ▢ None ▢ Pfizer ▢ Moderna ▢ J&J. Date of last dose: _____
Was it your ▢ 1st ▢ 2nd ▢ 3rd (booster) ▢ 4th (booster)

Diagnostic Studies

▢ Chest X-ray or ▢ Chest Cat Scan (CT)
When was it done _____
Where? ▢ VRI ▢ Other: _____

▢ Sinus X-ray or ▢ Sinus Cat Scan (CT)
When was it done _____
Where? ▢ VRI ▢ Other: _____

Questionnaire filled out by:

▢ Patient

▢ Father. Name: _____

▢ Mother. Name: _____

▢ Other. Relation & name: _____

If you have filled out this questionnaire prior to your appointment please fax to: (669)-242-7914