TARRANT MEDICAL ASSOCIATES | 4790 LITTLE RD, ARLINGTON, TX 76017 | P: 817-496-0766

# QUESTIONNAIRE

**Patient Name:** _____ **D.O.B.:** _____ **Date:** _____

| EARS | Now | Past |
|---|---|---|
| Hard of Hearing | ☐ | ☐ |
| Deafness | ☐ | ☐ |
| Ringing | ☐ | ☐ |
| Discharge | ☐ | ☐ |
| Earache | ☐ | ☐ |
| Itching | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Room Spins | ☐ | ☐ |

| NOSE | Now | Past |
|---|---|---|
| Decreased Smell | ☐ | ☐ |
| Bleeding | ☐ | ☐ |
| Pain | ☐ | ☐ |
| Discharge | ☐ | ☐ |
| Obstruction | ☐ | ☐ |
| Post Nasal Drip | ☐ | ☐ |
| Deviated Septum | ☐ | ☐ |
| Runny Nose | ☐ | ☐ |
| Seasonal Allergies | ☐ | ☐ |
| Sinus Congestion | ☐ | ☐ |
| Sneezing | ☐ | ☐ |

| THROAT | Now | Past |
|---|---|---|
| Soreness | ☐ | ☐ |
| Bad Tonsils | ☐ | ☐ |
| Hoarseness | ☐ | ☐ |
| Pain | ☐ | ☐ |
| Trouble Swallowing | ☐ | ☐ |
| Throat Infections | ☐ | ☐ |

| HEAD/EYES | Now | Past |
|---|---|---|
| Burning/Itching Eyes | ☐ | ☐ |
| Headaches | ☐ | ☐ |
| Chronic Sinusitis | ☐ | ☐ |
| Facial Pain Related to Sinus Pressure | ☐ | ☐ |

| MOUTH | Now | Past |
|---|---|---|
| Bleeding Gums | ☐ | ☐ |
| Sores | ☐ | ☐ |
| Dental Problems | ☐ | ☐ |
| Bad Breath | ☐ | ☐ |
| Loss of Taste | ☐ | ☐ |
| Dry Mouth | ☐ | ☐ |
| Ulcers | ☐ | ☐ |
| Blisters | ☐ | ☐ |

| SKIN | Now | Past |
|---|---|---|
| Color Changes | ☐ | ☐ |
| Eczema | ☐ | ☐ |
| Nail Changes | ☐ | ☐ |
| Hair Changes | ☐ | ☐ |
| Moles | ☐ | ☐ |
| Rashes | ☐ | ☐ |
| Sores | ☐ | ☐ |

| RESPIRATORY | Now | Past |
|---|---|---|
| Cough | ☐ | ☐ |
| Phlegm | ☐ | ☐ |
| Blood | ☐ | ☐ |
| Short of Breath | ☐ | ☐ |
| Wheezing | ☐ | ☐ |
| Congestion | ☐ | ☐ |
| Bronchitis | ☐ | ☐ |
| Asthma | ☐ | ☐ |

| GASTROINTESTINAL | Now | Past |
|---|---|---|
| Intestinal Disease | ☐ | ☐ |
| Stomach Problems | ☐ | ☐ |

| PSYCHIATRIC | Now | Past |
|---|---|---|
| Depression | ☐ | ☐ |
| Insomnia | ☐ | ☐ |
| Anxiety | ☐ | ☐ |

| GENERAL | Now | Past |
|---|---|---|
| Fatigue | ☐ | ☐ |
| Fever | ☐ | ☐ |
| Colds/Flus | ☐ | ☐ |
| Chronic Fatigue Syndrome | ☐ | ☐ |
| Chills | ☐ | ☐ |
| Night Sweats | ☐ | ☐ |
| Perspiration for no reason | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Chronic Sickness | ☐ | ☐ |
| Chronic Use of OTC/RX Drugs | ☐ | ☐ |
| Frequent Puffiness in the Face, Ankles, and Fingers | ☐ | ☐ |

| NEUROLOGIC | Now | Past |
|---|---|---|
| Migraines | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Fainting | ☐ | ☐ |

| ENDOCRINE | Now | Past |
|---|---|---|
| Weight Loss | ☐ | ☐ |
| Weight Gain | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Hot Flashes | ☐ | ☐ |

| MUSCULOSKELETAL | Now | Past |
|---|---|---|
| Muscle Pain | ☐ | ☐ |
| Muscle Weakness | ☐ | ☐ |
| Joint Pain | ☐ | ☐ |

| OTHER | Now | Past |
|---|---|---|
| _____ | ☐ | ☐ |
| _____ | ☐ | ☐ |
| _____ | ☐ | ☐ |
| _____ | ☐ | ☐ |
| _____ | ☐ | ☐ |

**Do Symptoms Interfere With Your Daily Activities?** ☐ All the Time ☐ Moderately ☐ A Little

**Other Medical Conditions:** ☐ Bee Sting Allergy ☐ Food Allergy ☐ Drug Allergy, *Specify:* _____

**Have you ever been treated for seasonal or perennial allergies?** ☐ Yes ☐ No

*If Yes, did the treatment Help You?* ☐ Yes ☐ No ☐ Unknown

**Are you currently taking medication for your Allergy Symptoms?** ☐ Yes ☐ No *If Yes, Please List:* _____

## DISQUALIFICATION QUESTIONS FOR TESTING:

**1. Do you have uncontrolled Asthma?** ☐ Yes ☐ No
**2. Are you currently taking Beta Blockers?** ☐ Yes ☐ No
**3. Do you have a history of Anaphylaxis?** ☐ Yes ☐ No
**4. Do you have Cancer?** ☐ Yes ☐ No
**5. Do you have an Immunodeficiency Disorder?** ☐ Yes ☐ No
**6. Are you currently pregnant?** ☐ Yes ☐ No

## TO BE COMPLETED BY PHYSICIAN ONLY - IMPRESSION/DIAGNOSIS:

**Atopic Dermatitis**
- ☐ L20.81 Atopic neurodermatitis
- ☐ L20.82 Flexural eczema
- ☐ L20.83 Infantile (acute)(chronic) eczema
- ☐ L20.84 Intrinsic (allergic eczema)
- ☐ L20.89 Other atopic dermatitis

**Asthma**
- ☐ J45.909 Unspecified asthma, uncomplicated
- ☐ J45.998 Other asthma
- ☐ J45.901 Unspecified asthma with (acute) exacerbation
- ☐ J45.902 Unspecified asthma with status asthmaticus
- ☐ J45.21 Extrinsic Asthma
- ☐ J44.1 Chronic Obstructive Asthma

**Conjunctivitis**
- ☐ H10.45 Chronic Conjunctivitis

**Rhinitis**
- ☐ J30.1 Allergic Rhinitis due to Pollen
- ☐ J30.81 Allergic Rhinitis (animal hair)
- ☐ J30.2 Other seasonal allergic rhinitis
- ☐ J30.89 Other allergic rhinitis
- ☐ J34.3 Hypertrophy Nasal Turbinates
- ☐ J34.3 Hypertrophy Nasal Turbinates

**Other**
- ☐ Z01.89 Diagnostic skin sensitization tests (Testing - 95004)
- ☐ Z51.89 Need for desensitization for allergens (Immunotherapy – 95165

**Physician ordering Testing, Signature:** _____ **Date:** _____