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DRUG REACTION QUESTIONNAIRE

INSTRUCTIONS: Carefully complete **all three sides**. Any item unmarked is considered a negative response to the question. Relate your answers to your own experiences, not to previous advice or skin tests. ALL INFORMATION WILL BE CONSIDERED CONFIDENTIAL.

Name Age Sex Race / Ethnicity Soc. Security #

Name of **ALL Florida Physicians:** _____ ____None

Name of **Florida Dentist**: _____ ____None

Preferred Pharmacies (Phone & Street Name) _____

CHIEF COMPLAINT and PRESENT ILLNESS:

Dates of Reactions	*Drug Involved*	*Name & Address of Physician, Dentist or Hospital*	*Symptoms: (Hives, wheezing, faint shock, vomiting, local swelling, swelling elsewhere on body)*

REVIEW OF SYSTEMS

Circle other problems you have experienced in the last year:

High blood pressure	Sore throat	Chest pain	Vaginal discharge/itch
Chills / fever	Swollen glands	Bronchitis/asthma	Burning urination
Feel faint	Stuffy/runny nose	Breast cysts	Hives/eczema
Dizziness	Sinus problems	Gallbladder problems	Joint aches and pains
Gum disease	Post nasal drip	Night sweats	Constipation
Glaucoma	Sneezing	Heartburn	Poor appetite
Itchy eyes	Cough	Nausea/vomiting	Weight loss
Earaches	Hoarseness	Cramps/diarrhea	Insomnia

Other **medical** or **psychological problems** in the last year: _____

_____ ____None

Attn. Coding Auditor: As per E/M guidelines, any items left uncircled, unchecked, or blank indicate a pertinent negative entry.

PAST MEDICAL/SURGICAL, SOCIAL AND FAMILY HISTORIES

Childhood: Breast fed, bottle fed, colic, croup, hives, eczema, frequent colds, recurrent earaches, tonsillitis, asthma, bronchitis, food allergies, headaches, hyperactive, learning disability, other:_____

Medical conditions for which you've ever had: diabetes, high blood pressure, stroke, heart condition, hiatal hernia, gerd/reflux, TB, pneumonia, COPD, hypothyroid, hashimotos, arthritis, glaucoma, cancer, HAE, immunodeficiency, hypoglycemia, sleep apnea, anxiety, depression, osteoporosis, learning disability, **other**:_____

_____

Surgeries & Year performed: _____ ____None

_____

Drug Allergy & Reaction: Penicillin, Erythromycin, Sulfa, Aspirin, Iodide, X-Ray dye, Novocain, Codeine
Other:_____ ____None

Medications/Supplements current: _____

_____

CPAP: yes no / **Oxygen**: yes no

Last ***Flu shot:***_____(mo/yr) Last P***neumonia shot***_____*(mo/yr)*
Last **Labs**:_____(mo/yr) with Dr._____ Last **CT**: sinus/chest_____(mo/yr) with Dr._____
Last **Cxr**:_____(mo/yr) with Dr._____ Last **skin biopsy** _____mo/yr) with Dr._____

Drug Usage: Marijuana, heroin, cocaine, body building steroids, recreational drugs ***How often?***_____ ____None
Menses: ***Last period***:_____(Date) Are you ***pregnant?*** Yes / No
Tobacco: (circle) Cigarettes, cigars, pipe ***Still Smoke:*** Yes / No ***Inhale:*** Yes / No
Number per day _____ ***Year started***_____ ***Year stopped*** _____ ***How many years***_____ ____Never
Are you ***exposed to smoke:*** ___ at home ___ at work ___ socially

Marital Status: (give parents' status if patient is a child)
Married, re-married, single, cohabitating, separated, divorced, widowed, gay / lesbian
Number of children: _____ Any adopted: ___ yes ___ no
If patient is child: ___ One residence ____ Time split between two parent's homes
Education level:_____
Alcohol Intake: Average per day _____ Type: ____Liquor _____ Beer ____Wine ____None

Hobbies:_____

Family Illnesses	***Self***	***Father***	***Mother***	***Brothers***	***Sisters***	***Children***	***Grand-parents***
Migraine							
Hives							
Eczema							
Hay Fever							
Sinus Condition							
Glaucoma							
Emphysema							
Asthma							
Cystic Fibrosis							
Tuberculosis							
Diabetes							
Thyroid Disease							
Heart Attack							
Stroke							
High Blood Pressure							
Cancer							
Other							

Attn. Coding Auditor: As per E/M guidelines, any items left uncircled, unchecked, or blank indicate a pertinent negative entry.___None

ENVIRONMENTAL and ALLERGY HISTORIES

How long have you lived ***in this area of Florida*** _____(years)
If a part-time resident, where is your ***other home*** (state/country) _____

Type of Dwelling → Condo, apartment, cement block house, wood house, dormitory, mobile home, boat
Fla home: ***Year Dwelling built:*** _____ ***Move in year:***_____
Out of state home: ***Year Dwelling built:*** _____ ***Move in year:***_____

HOW MANY OF EACH PET DO YOU HAVE:__Dogs, __Cats, __Birds, __Hamsters, __Rabbits, __Gerbils, __Guinea pigs, __Horses ___None My pets come: ___indoors ___strictly outdoor pets
Does your pet have **fleas:** Yes___ No___ Has pet had **mites?** Yes___ No___

	Fla.home	OOS home	
Pillow: Feather, foam, dacron / polyester,	_____	_____	(year purchased)
Mattress: Foam, inner spring, waterbed, air mattress, sleep number	_____	_____	(year purchased)
Mattress Topper / Bedpad: Feather, foam, dacron / polyester	_____	_____	(year purchased)
Blanket: Cotton, polyester, wool, feather comforter	_____	_____	(year purchased)
Flooring: Carpeting in: ___ ***Bedroom*** ___ ***Livingroom***	_____	_____	(year purchased)

A/C: ***Central Air*** ___yes ___no ***Wall unit*** ___yes ___no
Ceiling fans: ___yes ___no

Previous Allergy Evaluation: When: _____ (approximate year)
Allergist's name and city: _____
Allergies discovered at that time: _____

Are you ***now*** receiving ***allergy injections***? Yes / No Ever had an ***adverse reaction to allergy shots***? Yes / No
Injection contents _____
When was your ***last injection***? _____ ***How long*** have you been receiving them? _____(years)
Miscellaneous:
Have you ever had ***collagen, silicone implants*** or ***metal joint*** parts surgically placed in your body? _____None
Where in body / When: _____

Insect bites or stings: Large local swelling, itching all over body, rash all over body, weakness, sweating, shortness of breath, stuffy nose, wheezing, swollen eyes _____None

PATIENT SIGNATURE: _____

PHYSICIAN'S ANALYSIS OF DATA:

Dr. Signature: _____ Med Asst. Initials _____ Date: _____