the allergy station
Travis A Miller MD
phone/fax: (916) 238.6238
1478 Stone Point Drive Suite 290
Roseville CA 95661
theallergystation.com

# PATIENT HEALTH QUESTIONNAIRE

**PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.**

Name: _____ Date: _____

DOB: _____ Age: _____ Email: _____ Phone #: _____

Previously established with (please circle one): New Patient Dr. Miller Capital Allergy SacENT

1. What specific medical concerns bring you to our office? _____

_____

2. What is/are your health, wellness and management goals? _____

_____

3. Marital status (please circle one): Single Married Divorced Widowed Decline to answer

4. Name of your spouse or significant other: _____

5. Please describe your job /occupation/education: *(if retired, previous occupation)* _____

_____

6. If disabled, what is the nature of your disability? _____

7. Do you feel you eat a healthy diet? Please describe why or why not? _____

_____

8. Do you exercise regularly? Yes No

If yes, what type of exercises and how many days per week? _____

9. Have you ever smoked? Yes No If yes, # of products a day _____ Years _____

10. Do you still smoke now? Yes No If no, when did you quit? _____

11. Exposure to 2nd hand smoke? Yes No

12. Do you drink alcohol? Yes No If yes, how many drinks per day _____ or per week? _____

13. Do you drink caffeinated coffee, teas, or sodas regularly? _____ Number a day? _____

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14. Do you use recreational drugs? Yes No If yes, what drug(s)? _____

15. Have you ever tried to quit using a recreational drug? If yes, why? _____

16. Do you have Advanced Directives, DPA or a Living Will? If so, which? _____

17. Tell us about your home environment: *(e.g. live alone, with family, single parent, house, apt., pets, etc.)*

_____

18. Is there significant stress in your life? If so, which and why? _____

_____

## Medical Information

**Allergies:** Are you allergic to any medications? No If yes, please list with reactions: _____

_____

**Medications:** List all medications you are taking regularly- ***including over the counter, herbal or natural remedies***:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ Circle to see attached list

**Medical Illnesses or Conditions:** List any chronic conditions which you have been diagnosed to have.

**Have you ever been diagnosed to have:** Circle all that apply.

| | | | | |
|---|---|---|---|---|
| Allergies | Chicken Pox | Gout | Jaundice or Liver Disease | Stroke |
| Anemia | Depression | Heart Attack or Angina | Kidney Disease | Syphilis |
| Asthma | Diabetes or Pre-Diabetes | Heart Disease | Kidney Stones | TB/Lung Disease |
| Bleeding disorders | Digestive Disorder | Heart Murmur | Pleurisy | Thyroid Disease |
| Bone or Joint Disorders | Frequent Infections | Hemorrhoids | Pneumonia/Bronchitis | Ulcers/GERD |
| Cancer | German Measles | High Blood Pressure | Prostate Enlargement | |
| Cataracts | Glaucoma | High Cholesterol | Seizures/Epilepsy | |

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**Operations:** Please list any surgery and approximate month/year:

| Year | Operation |
|---|---|
| | |
| | |
| | |
| | |

**Hospitalizations:** Other than operations.

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Family Medical History | Age | Health (list significant illness) | Age at Death | If Deceased, List Cause | Comments |
|---|---|---|---|---|---|
| Mother | | | | | |
| Father | | | | | |
| Siblings | | | | | |
| Others | | | | | |

**Immunizations:** Circle if yes and indicate year of last injection. Do you have your vaccine card?

| | | |
|---|---|---|
| Influenza: | Pneumonia: | Tetanus: |
| MMR: | Hepatitis A or B: | "Shingles": |

**Transfusions:** Have you ever had a blood or plasma transfusion? (circle one): Yes No

**Weight:** What is your weight now? Maximum weight and when? _____

**Females Only:** Are you pregnant? Yes No Planning a pregnancy? Yes No Nursing a child? Yes No

Date of last menstrual period? _____ Menstrual Abnormalities: _____

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**Systems review:** Please indicate those items that have been **recurrent** or a **recent significant change.**

| Yes | No | Constitutional Symptoms |
|---|---|---|
| | | Good health lately |
| | | Recent significant weight change |
| | | Unusual fatigue or weakness |
| | | Frequent headaches, pain or inflammation |

| Yes | No | Eyes |
|---|---|---|
| | | Visual problems/changes |
| | | Eye disease or injury |
| | | Wear glasses/contact lenses |

| Yes | No | Ears/Nose/Mouth/Throat/Neck |
|---|---|---|
| | | Do you wear hearing aids |
| | | Hearing loss or ringing in ears |
| | | Earaches or drainage |
| | | Chronic sinus problems or runny nose |
| | | Change in smell |
| | | Nose bleeds/mouth sores |
| | | Bleeding gums |
| | | Sore throat/hoarseness or voice change |
| | | Lumps or swollen glands in neck |
| | | Difficulty swallowing |

| Yes | No | Respiratory |
|---|---|---|
| | | Chronic or frequent cough |
| | | Shortness of breath |
| | | Chest Tightness |
| | | Asthma or recurrent wheezing |
| | | Difficulty Exercising |
| | | Other |

| Yes | No | Cardiovascular |
|---|---|---|
| | | Heart trouble |
| | | Chest pain or angina pectoris |
| | | Palpitations |
| | | Shortness of breath with walking or lying flat |
| | | Swelling of the feet, ankles or hands |
| | | Waking at night with shortness of breath |

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| Yes | No | Gastrointestinal |
|---|---|---|
| | | Change of appetite |
| | | Stomach/abdominal pains or heartburn |
| | | Nausea or vomiting |
| | | Change in bowel movement |
| | | Painful bowel movements or constipation |
| | | Back pain |
| | | Other GI symptoms, Explain: |

| Yes | No | Musculoskeletal |
|---|---|---|
| | | Joint pain(s) |
| | | Joint stiffness/swelling or warmth |
| | | Weakness of muscles or joints |
| | | Muscle pain or recurrent cramps |
| | | Limitation of range of motion |

| Yes | No | Integumentary (Skin/Breasts) |
|---|---|---|
| | | Rashes or itching |
| | | Change in hair or nails |
| | | Hives or swelling |
| | | Change in skin color or moles |
| | | Other skin symptoms |

| Yes | No | Neurological |
|---|---|---|
| | | Frequent, recurring or increasing headaches |
| | | Light - headedness or dizziness |
| | | Convulsions, seizures or spasms |
| | | Numbness or tingling sensations |
| | | Tremors |
| | | Paralysis |
| | | Stroke |
| | | Head injury |

| Yes | No | Psychiatric |
|---|---|---|
| | | Memory loss or confusion |
| | | Nervousness |
| | | Insomnia |
| | | Depression |

| Yes | No | Endocrine |
|---|---|---|

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| | | |
|---|---|---|
| | | Glandular or hormone problem |
| | | Heat or cold intolerance |
| | | Excessive skin dryness |
| | | Excessive thirst or urination |
| | | Change in hand or glove size |

| Yes | No | Hematologic / Lymphatic |
|---|---|---|
| | | Slow to heal after cuts or wounds |
| | | Bleeding or bruising tendency |
| | | Recurrent anemia |
| | | Swelling, warmth or tenderness of veins or history of phlebitis |
| | | Swollen lymph nodes |
| | | Other |

| Yes | No | Allergic / Immunologic |
|---|---|---|
| | | History of skin reaction or other adverse reaction to: |
| | | Penicillin or other antibiotic: describe reaction: |
| | | Morphine, opiate reaction: |
| | | Lidocaine or other anesthetics reaction: |
| | | Aspirin or other pain remedies reaction: |
| | | Tetanus antitoxin or other serums |
| | | Other medications reactions: |
| | | Other known food allergies: |

| Yes | No | Genitourinary/Reproductive |
|---|---|---|
| | | Frequent urination burning or pain on urination blood in urine |
| | | Change in force or strain when urinating incontinence or dribbling of urine |
| | | Sexual difficulties |
| | | Changes in genitalia |
| | | Women: Painful periods irregular periods or recurrent vaginal discharge |
| | | Breast Pain, breast lump, breast discharge or rash |

**For women only:**

Number of pregnancies: _____ Number of deliveries: _____ Number of miscarriages: _____

Method of birth control (if applicable): _____ Menopausal since: _____

Date of last Pap: _____ Date of last mammogram: _____

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**Scans and Imaging:**

Date of DEXA scan: _____ Date of last Chest X-ray: ____

Date of last CT/MRI: _____ Other: _____

**Emergency Contact Information:**

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |

**Preferred Pharmacy:** Please list your pharmacy

| Name | Location | Phone Number |
|---|---|---|
| | | |

**Additional Comments:** _____

_____

_____

_____

_____

_____

_____

**Patient Name:** _____ **Date:** _____

**Signature:** _____