CHESHIRE MEDICAL CENTER
DARTMOUTH-HITCHCOCK • KEENE

Health Questionnaire for Allergy

Name: ____
Last First

PLEASE ANSWER YES IF YOU ARE CURRENTLY FEELING OR HAVE ANY OF THESE SYMPTOMS ON A REGULAR BASIS:

Please explain any Yes answers in the space provided

CONSTITUTIONAL

Fever	Y	N
Chills	Y	N
Headache	Y	N
Weight Loss	Y	N
Malaise	Y	N

Explain: ______________________________

EYES

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N

Explain: ______________________________

EARS, NOSE, THROAT

Ear Pain	Y	N
Change in hearing	Y	N
Trouble Swallowing	Y	N
Nose Bleed, drainage	Y	N
Sinus Problem	Y	N

Explain:______________________________

RESPIRATORY

Wheezing	Y	N
Shortness of Breath	Y	N
Frequent Cough	Y	N
Snore	Y	N
Cough(with blood)	Y	N

NEUROLOGICAL

Tremors	Y	N
Dizzy or lightheadedness	Y	N
Numbness/tingling	Y	N

Explain: ________________________

GASTROINTESTINAL

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Explain: ______________________________

CARDIOVASCULAR

Chest pain	Y	N
Angina	Y	N
Palpitations	Y	N
Shortness of breath on exertion	Y	N
Shortness of breath at night	Y	N

Explain: ______________________________

MUSCULOSKETAL

Joint Pain	Y	N
Bone Pain	Y	N
Arthritis symptoms	Y	N
Fibromyalgia	Y	N

Explain: ______________________________

HEMATOLOGIC/LYMPHATIC

Swollen lymph node/gland	Y	N
Blood clotting problems	Y	N
Phlebitis	Y	N

Explain: ______________________________

SKIN CONDITION

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Explain: ______________________________

ENDOCRINE

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Explain: ______________________________

CURRENT MEDICATIONS:

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