Allergie-Ambulatorium Innere Stadt

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M E D I C A L Q U E S T I O N N A I R E

Dear patient!

Please fill in this questionnaire before talking to the doctor. It will help us to get to the point more quickly.

Patient data: .....Date: .....

NAME: .....

Date of birth: ..... insurance number: ..... insurance company: .....

Phone/ FAX: ..... e-mail:.....

Adress: .....

Present occupation/profession: .....

Working adress: .....

If the patient is not personally insured**- data of the insured person**:

NAME: .....

Date of birth: .....insurance company (and number): .....

Workingadress: .....

- **Reasons for coming here:**
  - ❍ coughing
  - ❍ breathing difficulties
  - ❍ running nose
  - ❍ sneezing
  - ❍ blocked nose
  - ❍ itching eyes
  - ❍ swollen eyelids
  - ❍ itching palate
  - ❍ itching skin
  - ❍ rashes
  - ❍ digestive problems
  - ❍ others:
  - ❍ .....
    .....

- **When did this start**?.....

- **Is there any connection to the time of the day (when is it worst)?**
  - ❍ in the morning
  - ❍ at noon
  - ❍ in the evening
  - ❍ at night
  - ❍ at different times
  - ❍ after the meal
  - ❍ all day

- **Is there any season, when it is worst (e. g.: easter, summer, winter, ...)?**
  - ❍ months (from / to): .....
  - ❍ all year round

- **Symptoms are worst**
  - ❍ at home
  - ❍ in the open air
  - ❍ because of your hobby, which is:
    .....
  - ❍ at your workingplace
  - ❍ after consumption of certain food - namely:
    .....

- **For testing allergy a blood sample has to be taken. Would you like to**
  - ❍ sit or
  - ❍ lie down during the process

PLEASE TURN!

- Do you have any contact with irritating or toxic substances (at work, due to your hobby,...)?

❍ Yes ❍ No

- Do you take any **allergy-medication at present**? **Which**?

  .....

- Did you ever have troubles in connection with
  - ❍ food
  - ❍ medication
  - ❍ insect stings
  - ❍ costume jewellery
  - ❍ vaccinations
  - ❍ others: .....
- Do you, or anyone living with you, smoke?
  - ❍ No, I don´t
  - ❍ Yes, at most ..... cigarettes a day
  - ❍ Yes, I live in a smokers household
- Do you have any **pet or contact with an animal**? If yes, with which?

  .....

- Which problems do you have in contact with a pet?
  - ❍ None
  - ❍ .....
- Do you have **plants** at your home?
  - ❍ Yes
  - ❍ No
- Is your flat infested with mould?
  - ❍ Yes
  - ❍ No
- What does your mattress consist of: ..... .(e.g. latex, horse hair)
  Your cushion:…..... .....….(e.g. feathers, foam material)
  Your quilt: ..... (e.g. wool, feathers, silk))
- Does anyone in your family suffer from an allergy (parents, siblings, grand parents)?
  - ❍ No
  - ❍ Yes, namely: .....
- Have you already undergone an allergy-test?
  - ❍ No
  - ❍ Yes ..... years ago, at: .....

  The following **allergies were found:**.....
- **Do you suffer / or have you ever suffered from hepatitis / HIV**
  - ❍ No
  - ❍ Yes
- **Do you suffer from any other disease (e.g. high blood-pressure)?**
  - ❍ No
  - ❍ Yes, namely: .....
- Is there any medication you take regularly?
  - ❍ No
  - ❍ Yes, namely: .....

PLEASE NOTE: The medical report will be sent to your doctor and to your adress several days after your **final** visit.

If you want an additional medical report to be sent to your home address please deposit **€ 0,68** for stamp.