



Allergy, Asthma & Immunology Associates, P.C.

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Recurrent Infections Questionnaire

Patient Name: _____

Today's Date: _____

Date of Birth: _____

Referring MD: _____

1. What is your major problem(s) which brought you here? _____

2. How long have you had these infections?

_____ weeks _____ months _____ years

3. Have you taken antibiotics? Yes No

Have they helped? Yes No

4. For these infections, have you been: hospitalized had surgery received IV antibiotics

5. Have you had infections of the:

Ears Intestines Brain Bone

Sinuses Skin Genitourinary tract

Lungs Kidneys Female reproductive tract

6. Have you had any of the following:

Fever/Chills Swollen glands Fatigue Muscle or Joint pain/swelling

Thrush Chronic Diarrhea Frequent Skin Rashes Unexplained weight loss

Warts Shingles Chronic Cough

7. Did you have a blood transfusion or blood products between 1977-1985? Yes No

Have you used IV drugs? Yes No

Have you been test for AIDS? Yes No

8. Are you in an occupation which puts you at increased risk, i.e. Healthcare giver?

Healthcare giver for children Day care center worker Frequent Travel

Frequent exposure to animals Babysitter with many children Teacher

9. Are there any factors which may predispose you to many infections? Steroids

Irritants Smoke Allergies Chemical fumes Cancer Treatment

Seasonal _____

10. Do you have other family members, relatives with frequent infections?

- Mother Father Brother Sister Grandparents
 Aunt Uncle Males Other _____

11. Family history of Hospitalizations / deaths from infections? Yes No

12. Any allergies in the family? Yes No

13. Any foreign or domestic travel recently, particularly to areas where acquisition of infections may be more likely, poor sanitation, "camping", etc.? Yes No

14. Any previous evaluations? Yes No

- Labs X-rays CT Scan MRI Immune studies

15. Are your immunizations up to date?

- DPT (Diphtheria, Pertussis, Tetanus) Td (Tetanus & Diphtheria) Flu Shots
 Pneumovax (Pneumoccal) Hepatitis Other: _____

16. Have you seen any other specialists? Yes (*list*) _____ No

17. Do you have allergies to any medications or vaccines? Yes _____ No

18. Any other information which would be helpful in clarifying your disease?


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Doctors Comments: \_\_\_\_\_

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