New York Medicine Doctors
NYMDCenter.com

IMMUNE SYSTEM QUESTIONNAIRE

Name: _____DOB: ____/____/____ Date: ____/____/____

Have you experienced any of the following symptoms within the past year?

Head/Sinuses	Respiratory	Eyes	Skin	Misc.
Headaches ☐	Snoring ☐	Itchy/Watery Eyes ☐	Hives ☐	Fatigue/Depression ☐
Sinus Congestion ☐	Poor Sense of Smell/Taste ☐	Redness/Swelling ☐	Redness/ Irritation ☐	Anxiety/ Sleeplessness ☐
Sneezing ☐	Coughing ☐	Burning/Dryness ☐	Eczema ☐	Vaginitis ☐
Nasal Congestion ☐	Wheezing ☐	Foreign Body Sensation/Crust ☐	Cheilitis (Lip Swelling/Chapped) ☐	UTI (Urinary Tract Infection) ☐
Sinus / Ear Infections ☐	Shortness of Breath ☐	Dark circles (Racoon Eyes) ☐	Dry/flaky/ ashy skin ☐	Frequent Yeast Infections ☐
Runny Nose ☐	Chest Tightness ☐	Other:		
Itchy Nose ☐	Phlegm/Sputum ☐			
Nasal Polyps ☐	Hoarseness ☐			
Post Nasal Drip ☐	Sore Throat ☐			

Are your symptoms: Seasonal, Year-round, or both?

_____

How many Colds or Flu illnesses have you had in the past year?

_____

Which month are they worst?

January ☐	February ☐	March ☐	April ☐	May ☐	June ☐
July ☐	August ☐	September ☐	October ☐	November ☐	December ☐

Do these symptoms disturb your sleep? _____ **If so, how often?** 2 or less times a month, 34 times a month, 2-6 times a week, or every night

_____

Do/did either of your biological parents have a history of seasonal or food allergies, or immune system disorders? If so, please explain: _____

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Name: _____DOB: ____/____/____ Date: ____/____/____

Have any of the following bothered you or triggered your symptoms?

Pollen	☐	Cosmetics	☐	Grass/Leaves	☐	Cats	☐	Cold air/ Humidity	☐
Odors	☐	Mold/mildew	☐	Drafts	☐	Dogs	☐	Weather changes	☐
Smoke	☐	Basements	☐	Aerosol Sprays	☐	Horses	☐	Pollution/Air Quality	☐
Latex (rubber)	☐	House dust	☐	Nervousness/Stress	☐	Hay	☐	Exercise	☐
Foods (list the source and the reaction):				Other animals (specify):				Other (list the source and the reaction):	

In regard to possible food allergies, do you experience any of the following?

Nausea, diarrhea, or vomiting ☐	Bloating after eating ☐	Constipation ☐	Stomach pain ☐	Indigestion ☐	Tingling of the mouth ☐

Please check the appropriate answer for each question below:

1) Are you taking any antihistamines? (Claritin, Benadryl, Allegra) ☐ **YES** ☐ **NO**

2) Do you have asthma? ☐ **YES** ☐ **NO** ☐ **NOT SURE**
   If **YES**, when was your last attack? _____

3) Were you ever hospitalized due to allergies? ☐ **YES** ☐ **NO**
   If YES, please explain:_____

4) Are you pregnant? ☐ **YES** ☐ **NO** ☐ **NOT SURE**

5) Do you suffer from any autoimmune diseases? ☐ **YES** ☐ **NO**
   If you do, which one(s): _____

6) Do you have cancer? ☐ **YES** ☐ **NO**