

☐ Dr. Kobayashi ☐ Dr. Tracy ☐ Dr. Kettelhut ☐ Dr. Friedlander

Recurrent Infections Questionnaire

Patient Name: _____ Date of appointment: _____

Date of Birth: _____ Referring MD: _____

Race ☐ White ☐ Black or African ☐ American Indian or Alaskan Native ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic
(Race will be used for laboratory purposes)

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

2. Describe symptoms:

☐ Fevers	☐ Swollen glands	☐ Fatigue	☐ Muscle or Joint pain/swelling
☐ Thrush	☐ Chronic Diarrhea	☐ Frequent Skin Rashes	☐ Unexplained weight loss
☐ Warts	☐ Shingles	☐ Chronic Cough	☐ Loss of appetite
☐ Other _____			

3. Have you had recurrent:

☐ Sinus infections	☐ Pneumonia	☐ Ear infections	☐ Ear infections during childhood
☐ Bronchitis	☐ Skin Infections	☐ Genitourinary tract infections	
☐ Viral Infections	☐ Gastrointestinal tract infections	☐ Other _____	

4. How long have you been suffering from recurrent infections? _____month(s) _____year(s)

5. How often do you get these infections? Every _____week(s) Every _____month(s)

6. Have you taken multiple antibiotic courses? ☐ No ☐ Yes - *How many?* _____
Have they helped? ☐ No ☐ Yes

7. For these infections, have you been hospitalized? ☐ No ☐ Yes - *Where? When? Explain below.*

8. Did you have a blood transfusion or blood products between 1977-1985? ☐ Yes ☐ No
Have you used IV illicit drugs? ☐ No ☐ Yes - *what?* _____
Have you been tested for AIDS/HIV? ☐ No ☐ Yes - *result?* _____

9. Are you apart of any of the following which may put you at increased health risk?

☐ Healthcare Professional	☐ Day care center worker/ Nanny
☐ Frequent exposure to animals	☐ Teacher
☐ Foreign Travel	☐ Domestic travel
☐ Camping	

10. Mark any factors which may predispose you to many infections:

- ☐ Irritants ☐ Smoke ☐ Allergies ☐ Chemical fumes ☐ Cancer Treatment
☐ Steroids ☐ Other _____

11. Please list any of your other diagnoses/ health problems (*i.e. high blood pressure, diabetes, heart conditions, cancer, thyroid problems, arthritis, depression, anxiety, eczema*)

12. Family History (*mark applicable*):

- ☐ Allergies ☐ Hives (welts) ☐ Eczema (skin allergy condition)
☐ Food Allergies ☐ Asthma ☐ Angioedema (swelling condition)
☐ Immune deficiencies -*who?* _____
☐ Recurrent respiratory/sinus infections -*who?* _____

13. Past Surgical History: ☐ None

- ☐ Tonsillectomy *Date:* _____ ☐ Adenoidectomy *Date:* _____
☐ Sinus Surgery *Date:* _____ ☐ Ear Tubes *Date:* _____

Please list all other surgeries:

14. Diagnostic evaluations in the last two years:

- ☐ Labs/immune labs- *when?* _____ *where?* _____
☐ X-rays (chest or sinus) - *when?* _____ *where?* _____
☐ CT Scan (chest or sinus)- *when?* _____ *where?* _____
☐ Cultures - *when?* _____ *where?* _____
what? _____

15. Are your immunizations up to date? ☐ Yes ☐ No

- ☐ Td (Tetanus & Diphtheria) *Date:* _____
☐ Pneumovax *Date:* _____ ☐ Prevnar13 *Date:* _____

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

17. Any known allergies to any medications or vaccines? ☐ No ☐ Yes (*list*) _____

18. List ALL of your medications/supplements (*include any creams, inhalers, sprays*)

Include dose and frequency. **PHARMACY:** _____

_____	_____
_____	_____
_____	_____
_____	_____

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