



## PATIENT QUESTIONNAIRE

We are vitally interested in the development of new medications for the treatment of allergic diseases. We are involved in many research studies with various pharmaceutical companies who are ready to introduce new treatments for allergic diseases. Some studies offer patient compensation for time and travel. If you are interested in taking part in one of our future medication trials, please fill out this form.

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Parent/Guardian Name (if under 18): \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: M/F Ethnic Background: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Phone (home):(\_\_\_\_) \_\_\_\_\_ (work):(\_\_\_\_) \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have asthma? \_\_\_\_\_ When did it begin? \_\_\_\_\_ Do you have allergies? \_\_\_\_\_

What type of allergies? \_\_\_\_\_

Do you have: Sinusitis? \_\_\_\_\_ How often? \_\_\_\_\_ Do you have or get hives? \_\_\_\_\_

Other medical conditions? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Were you ever a smoker? \_\_\_\_\_ If "yes", when did you quit? \_\_\_\_\_

How long did you smoke? \_\_\_\_\_ Are you allergic to Aspirin or other pain relievers? \_\_\_\_\_

List any other medications you are allergic to: \_\_\_\_\_

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Are you on allergy shots? \_\_\_\_\_ How long? \_\_\_\_\_

May we call you when your profile fits a particular study criteria to determine if you are interested in that trial?  
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Thank you for taking the time to complete this questionnaire. 😊