Santa Fe Center for Allergy & Environmental Medicine

W.A. Shrader, Jr., MD

Initial Questionnaire Neurology/Cardiovascular

PLEASE PRINT

1. Name of physician who cares for your condition _____
2. What is your diagnosis? _____
3. When were you first diagnosed? _____
4. Do you recall the name(s) of the test(s) that were used to determine your diagnosis?

   _____
5. When did you first start having symptoms? _____
6. Please list your worst symptoms now: _____

   _____
7. How well are your symptoms controlled? □ 100% □ 75% □ 50% □ 25% □ less than 25%
8. Are you unable to work because of your symptoms? □ Yes □ No
9. Are you on disability because of your symptoms? □ Yes □ No
10. Do you have hay fever, asthma, rashes or other allergies? □ Yes □ No
    If so, please list below:

Problem	Seasonal	All year

11. Do you have food allergies, or do any foods bother you in *any way* when you eat them (or drink them), and if so what foods?

    _____

    _____
12. Are you allergic to any medications? □ Yes □ No If so, please list:

    _____

    _____