ADVERSE DRUG REACTION QUESTIONNAIRE

Demographic Data

Name: ___________________________ DOB: ________________ Date: ________________

Address: ______________________________________________________________________

Telephone:                                      Home__________________________
                                            Work: ___________________________
                                           Cell: _____________________________

Emergency Contact: ______________________________________________________________________

Relation: ____________________________________________________________________________

Address: ____________________________________________________________________________

Telephone: ____________________________

Referring Physician: ____________________________

Address: ____________________________________________________________________________

Telephone: ____________________________
Allergy History

Chief Complaint:

What Medication caused your reaction? ____________________________________________

Why were you receiving this medication? __________________________________________

When did you receive this medication? __________________________________________

How many times have you received this medication? ________________________________

Do you receive other medications with or just before this medication? ________________

For intravenous drugs:
   When during the infusion did the reaction occur? ________________________________

For oral drugs:
   How long after taking the medication did the reaction occur? ______________________
   How many doses did you take before the reaction? ________________________________

Treatment of reaction:
   What treatment did you receive for your reaction? ________________________________
   Did you go to the emergency room? ____________________________

Have you taken this medication since your reaction? ________________________________

Present Illness:
Describe your reaction? (Check all boxes that apply, circle all symptoms that apply)

☐ Skin: flushing/redness/warmth
☐ Itching
☐ Rash: appearance __________________________ Location __________________________
☐ Nasal congestion
☐ Throat symptoms
☐ Cough
☐ Back pain
☐ Abdominal pain
☐ Nausea/Vomiting/Diarrhea
☐ Fever
☐ Joint: pain/swelling/redness/stiffness
☐ Numbness/tingling
☐ Changes in blood pressure: High __________ Low _________________
☐ Dizziness
☐ Tunnel vision
☐ Sense of doom
☐ Loss of consciousness
Past Medical History:
Have you been told or do you think you have any of the following?
- Allergic rhinitis/hay fever
- Asthma
- Eczema
- Hives
- Unexplained skin swelling
- Nasal polyps
- Sinusitis
- Ear infections
- Bronchitis/pneumonia
- Diabetes
- Tuberculosis
- Gastro esophageal reflux
- High blood pressure
- Heart Disease
- Cancer
- Other: ____________________________________________________________

Medication:
Include vitamins, aspirin, pain medications, blood pressure medications (ACE inhibitors), beta-blockers, chemotherapy, herbal therapies, and other current medications.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

If you have cancer, what other chemotherapy have you received? __________________________________
________________________________________________________________________________________

If you take frequent antibiotics, what other antibiotics have you tolerated before? __________________
________________________________________________________________________________________

Allergies:
Do you have additional allergies? Please list and describe the reaction.
> Other Medications: ________________________________________________________________
> Foods/Food additives: __________________________________________________________
> Insects: ________________________________________________________________
> Latex (rubber products): _______________________________________________________

Have you undergone an Allergy evaluation in the past? Yes _____ No _____
> If so, when and where? ______________________________________________________________
> Skin test results: ________________________________________________________________

Previous allergy injections? Yes _____ No ______
Social History:

What is your occupation? ____________________________________________________________________

Are you married? __________________________________________________________________________

Do you have children? _____________________________________________________________________

Are you pregnant or are planning on getting pregnant? ________________________________

Who lives with you at home? __________________________________________________________________

Do you smoke? __________________________________________

   How many years have you smoked? ______________________________________________________

   Approximately how many packs/day do you smoke? _________________________________________

   If you have smoked in the past, when did you stop? ______________________________________

Do you drink alcohol? ______________________________________________________________________

   Approximately how many drinks/week do you have? _________________________________________

Do you use recreational drugs? _______________________________________________________________________________________

   Which ones? _____________________________________________________________________________

   When did you use each drug listed? ________________________________________________________

Family History:

List all of your close relatives who have:

   Allergies: _____________________________________________________________________________

   Asthma: _______________________________________________________________________________

   Adverse Drug Reactions: __________________________________________________________________

   Eczema: _______________________________________________________________________________

   Cancer: _______________________________________________________________________________

   Coronary artery disease: __________________________________________________________________

Other:

Do you have any questions and/or concerns that you would like to discuss? __________________________

_________________________________________________________________________________________

What would you like to accomplish with today’s visit? _____________________________________________

_________________________________________________________________________________________

Have you (or has the child for whom you are filling out this form) ever felt unsafe or been afraid of anyone (i.e. your partner, a relative, or anyone else)? _____________________________________________

_________________________________________________________________________________________

Do you experience pain as part of your daily life? _____________________________________________

   Describe the location, onset, duration, and characteristics of your pain (i.e. ache, burn throb, sharp).

   On a scale from 1-10, 1 being the least pain and 10 being the greatest pain, how would you describe your pain? _____________________________________________________________________________

   How do you treat your pain? _____________________________________________________________________________

Do you have a Health Care Proxy, Advance Directive or Living Will? I yes, please identify. ____________

_________________________________________________________________________________________
### Review of Patient Systems - Patient must complete this questionnaire

<table>
<thead>
<tr>
<th>General</th>
<th>Yes</th>
<th>NO</th>
<th>Neck:</th>
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<tbody>
<tr>
<td>Recurrent fever</td>
<td></td>
<td></td>
<td>Swelling</td>
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<tr>
<td>Large weight loss/gain</td>
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<td></td>
<td>Lumps</td>
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<tr>
<td>Difficulty sleeping</td>
<td></td>
<td></td>
<td>Other:</td>
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<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Skin:</td>
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<table>
<thead>
<tr>
<th>Eyes:</th>
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<tbody>
<tr>
<td>Blurred vision</td>
<td></td>
<td></td>
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<tr>
<td>Light flashes</td>
<td></td>
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<tr>
<td>Pain in eyes</td>
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<td>Other:</td>
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<tr>
<th>Ear /Nose/Throat:</th>
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<tbody>
<tr>
<td>Hearing difficulty</td>
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<tr>
<td>Nose bleeds</td>
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<tr>
<td>Sinus trouble</td>
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<tr>
<td>Ear pain/popping</td>
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<tr>
<td>Mouth/tooth/tongue problems</td>
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<tr>
<td>Persistent hoarseness</td>
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<td>Other:</td>
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<thead>
<tr>
<th>Cardiovascular:</th>
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<tbody>
<tr>
<td>Fluttering heart</td>
<td></td>
<td></td>
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<tr>
<td>Unusual heartbeat</td>
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<tr>
<td>Chest pain</td>
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<td>Swollen ankles</td>
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<tr>
<td>High blood pressure</td>
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<td>Other:</td>
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<thead>
<tr>
<th>Respiratory:</th>
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<tbody>
<tr>
<td>Shortness of breath</td>
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<td>Poor exercise tolerance</td>
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<td>Persistent cough</td>
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<td>Wheezing</td>
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<tr>
<td>Other:</td>
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<thead>
<tr>
<th>Genitourinary:</th>
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<tbody>
<tr>
<td>Genital pain/burning urination</td>
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<tr>
<td>Up at night to urinate</td>
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<td></td>
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<tr>
<td>Kidney stones</td>
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<tr>
<td>Problems with menstruation</td>
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<tr>
<td>Other:</td>
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<thead>
<tr>
<th>Gastrointestinal:</th>
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<tbody>
<tr>
<td>Indigestion/heartburn</td>
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<td></td>
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<tr>
<td>Abdominal pain</td>
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<tr>
<td>Diarrhea</td>
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<tr>
<td>Black tar-like stools</td>
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Patient Signature __________________________________________
Reviewed By ____________________________________
Date: ______________________

Name: ______________________
Date: ____________

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Note: The document is a questionnaire for patients to report any symptoms they are experiencing. The patient must answer 'Yes' or 'No' to each question, with options for additional notes or specific symptoms like 'Other:', 'Endocrine:', 'Bones/Joints:', 'Muscle pain/tenderness', 'Psychological:', 'Communication Concerns', etc.
Did you receive a copy of the “We Care About Your Safety Brochure”?   Yes ____ No ____

Do you understand how to prevent the spread of germs?   Yes ____ No ____

Reviewed by:
Physician  _____________________________ MD  CID

Name: _____________________________
Date: _____________________________