BRIGHAM AND WOMEN'S HOSPITAL

Name: _____
Date: _____

ADVERSE DRUG REACTION QUESTIONNAIRE

Demographic Data

Name: _____ DOB: _____ Date: _____

Address: _____

Telephone:
Home_____

Work: _____

Cell: _____

Emergency Contact: _____

Relation: _____

Address: _____

Telephone: _____

Referring Physician: _____

Address: _____

Telephone: _____

Name: _____
Date: _____

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*

Name: _____
Date: _____

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** _____

Name: _____
Date: _____

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. _____
_____

Name: _____
Date: _____

Review of Patient Systems-Patient must complete this questionnaire

General	**Yes**	**NO**	**Neck:**	**Yes**	**No**
Recurrent fever			Swelling		
Large weight loss/gain			Lumps		
Difficulty sleeping			Other:		
Other:			**Skin:**		
Eyes:			Changing mole		
Blurred vision			Rashes		
Light flashes			Bruise easily		
Pain in eyes			Other:		
Other:			**Endocrine:**		
Ear /Nose/Throat:			Constant thirst		
Hearing difficulty			Too warm/too cold		
Nose bleeds			Jumpy/nervous		
Sinus trouble			Other:		
Ear pain/popping			**Bones/Joints:**		
Mouth/tooth/tongue problems			Painful joints		
Persistent hoarseness			Swollen joints		
Other:			Muscle pain/tenderness		
Cardiovascular:			**Neuromuscular:**		
Fluttering heart			Weakness in arm/leg		
Unusual heartbeat			Difficulty with balance		
Chest pain			Dizzy, fainting spells		
Swollen ankles			History of seizure		
High blood pressure			Other:		
Other:			**Psychological:**		
Respiratory:			Do you find life:		
Shortness of breath			Unsatisfactory		
Poor exercise tolerance			Too demanding		
Persistent cough			Boring		
Wheezing			Satisfactory		
Other:			**Do you:**		
Genitourinary:			Cry easily		
Blood in urine			Feel depressed		
			Have many fears		
Pain/burning urination			Feel anxious		
Up at night to urinate			**Have you ever:**		
Kidney stones			Considered suicide		
Problems with menstruation			Attempted suicide		
Other:					
Gastrointestinal:					
Indigestion/heartburn			**Communication Concerns**		
Abdominal pain					
Diarrhea					
Black tar-like stools					

Patient Signature _____ **Reviewed By** _____
Date: _____ **Date:** _____

Name: _____
Date: _____

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
