Comprehensive Allergy and Asthma Care Center

New Patient Questionnaire

Patient Name: _____ Age:_____ DOB: _____ Sex: M F

Primary Physician (Name, Address and Phone Number):

_____

_____

Do you want the allergy consultation note sent to this physician? Yes No

Please answer all questions to the best of your ability. Base your answers on your own observations and not on what others have told you or what you may have assumed on the basis of previous allergy tests. Please complete this form before seeing the allergist as the information will help us understand your problem.

What are the problems that bring you to an allergist?

_____

_____

Please indicate the symptoms you experience:

EARS	**Yes**	**No**	**THROAT**	**Yes**	**No**
Itching			Soreness		
Fullness			Post Nasal Drip		
Popping			Itching of Palate		
Tubes placed			Recurrent Strep		
Hard of hearing			Hoarseness		
Frequent infections			Clearing throat		
#infections/year			Tonsils/Adenoids removed		
NOSE/SINUS			**EYES**		
Repeated sneezing			Contact lenses		
Watery discharge			Itching		
Stuffy nose			Burning		
Itching			Watering		
Nasal trauma			Swelling		
Nose bleeding			Redness		
Poor sense of smell			Discharge		
Mouth breathing			Glaucoma		
Bad breath			Cataract		
Snoring			**SKIN**		
Headaches			Eczema		
CHEST			Hives		
Cough			Swelling		

Wheezing		Infections	
Phlegm		Skin rash	
Shortness of breath		**ASTHMA**	
At rest		When diagnosed?	
With exercise		ER/hospital visits?	
Coughed up blood		Last use of oral steroid?	
Heartburn/Reflux		Days of work missed?	
Bronchitis		Any use of Xolair?	
Pneumonia			

How long have you had symptoms? _____

When do symptoms occur (Circle) Spring Summer Fall Winter All year

Are symptoms worse after exposure to any of the following: (Circle)

Raking leaves	Humidity/heat	Cigarette smoke	Lawn mowing	Cold air
Perfumes	Hay/compost	Air conditioning	Strong odors	Damp basement
Weather changes	Seasonal changes	Animals/pets	Smog (exhaust)	

How many times a year are you treated with antibiotics for nasal/sinus/lung infections ? _____

During which months of the year do you have sinus infections? _____

For how long each time?_____

Any sinus surgery? (Circle) Tonsils Adenoids Sinus Nasal Septal Nasal Turbinate

Do you have a diagnosis of immunodeficiency (decreased immune system)? Yes No

Have you ever been seen by an allergist? _____Any skin testing? _____

Have you ever been on allergy shots? _____ For how long? _____

Have you ever had anaphylaxis (severe allergy reaction)? Yes No When ? _____

Do you have problems wearing LATEX GLOVES or using latex products? Yes No

Do you have problems with radiographic IV contrast or anesthesia? Yes No

After a bee sting do you have problems with: (Circle)

Swelling Hives Tongue/Lip swelling Shortness of breath

Have you ever been to the emergency room for a reaction to a sting? Yes No

Have you had any adverse reactions to vaccinations? Yes No

Are immunizations up to date? Yes No

BIRTH HISTORY (complete for children less than 12 years old)

Term Preterm NICU Nursery RSV in first year of life

PAST MEDICAL HISTORY (Please list any ongoing medical problems)

_____

_____

_____

ALLERGY/ASTHMA MEDICATIONS (Name, Frequency, Helpful/Not helpful)

_____ _____ Helpful/Not helpful

_____ _____ Helpful/Not helpful

_____ _____ Helpful/Not helpful

_____ _____ Helpful/Not helpful

_____ _____ Helpful/Not helpful

MEDICATIONS (Please list OTHER mediations that you are currently taking, dosage, frequency, and for what condition.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

DRUG ALLERGIES/SENSITIVITIES (Please list medication and type of reaction)

_____ _____

_____ _____

_____ _____

_____ _____

FOOD ALLERGIES/SENSITIVITIES

Do you have problems with any foods? If yes, name the food and describe the problem.

(Swelling or itching of tongue, lips, or mouth? Hives or skin rash? Vomiting or diarrhea?)

Food Symptom

_____ _____

_____ _____

_____ _____

SURGICAL HISTORY (Please list type and date of any surgical procedures)

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

	Asthma	Allergies	Eczema	Food Allergy	Insect Allergy	Hives	Other
Mother							
Father							
Sister							
Brother							
PGrandma							
PGrandpa							
MGrandma							
PGrandpa							
Uncle							
Aunt							
Cousin							

SOCIAL HISTORY

Do you smoke? Yes No Do you have a history of smoking? Yes No

If yes, how many packs per day and for how many years? _____

Does anyone in your home smoke? Yes No Any history of substance abuse? Yes No

Do you have any pets? Yes No If yes, what type? _____

How long have the pets been with you?_____

Does the animal have full use of the house? Yes No

Does the animal sleep on the patient's bed? Yes No

Does animal exposure make symptoms worse? Yes No

Prior state(s) you have lived in? _____

What type of home do you live in? (Circle) Apartment Condo Townhome House Trailer

How long have you lived in the home?_____

Is there a basement? Yes No Is the basement? (Circle).... Dry Damp

Any previous mold issues in the home? Yes No Any previous water leaks in the home? Yes No

Is there A/C ? (Cirlce) Window unit Central

Heating? (Circle) Gas Fireplace Electric

Any use of a dehumidifier? Yes No Any use of a humidifier? Yes No

What type of flooring in the home? Hardwood Carpet Tile

How often do you wash your linen? _____

Any feather p illows? Yes No Any down comforters? Yes No

Any hypoallergenic bedding? Yes No Do you have upholstery furniture? Yes No

Fabric Curtains? Yes No Any stuffed animals on your bed or in your bedroom? Yes No

SYSTEM REVIEW (Circle):

General	Fever, Weight loss/gain, Fatigue, Change in appetite
Neuro	Headaches, Seizures, Stroke, Dizziness, Confusion, Loss of Sensation (tingle)
Cardio	High Blood Pressure, Palpitations, Murmur, Chest Pain, Pacemaker
Extremities	Arthritis, Fractures, Sprains, Loss of Color (turning blue or white), Pain
Abdomen	Heartburn/Reflux, IBS, ,IBD, Nausea, Diarrhea, Constipation
Endocrine	Thyroid condition, Diabetes
Hematology	Anemia, Sickle Cell
Oncology	Any type of cancer
Immune	HIV, Lupus,

OTHER

Are there any other concerns not addressed in this questionnaire that you would like to discuss with the doctor? Please list below.

Patient name: _____

Patient/Guardian signature: _____

Date: _____

Physician signature of review: _____