ALLERGY, ASTHMA AND IMMUNOLOGY CENTER – NEW PATIENT QUESTIONNAIRE

PATIENT NAME: ____ **AGE:** __________ **DOB:** ___________________________

REFERRING PROVIDER (If any): ____ **REFERRING TELEPHONE:** ____________________

PRIMARY CARE PHYSICIAN: ____ **PCP TELEPHONE:** __________________________

PHARMACY: (Please list pharmacy name and location) ____

WHO COMPLETED THIS QUESTIONNAIRE: *(if other than patient)* ____

CHIEF COMPLAINT(s): (Describe the reason for your visit and what problems or symptoms you are having)

____

____

____

WHEN DID SYMPTOMS BEGIN: ____

DURATION (HOW LONG HAVE SYMPTOMS OCCURRED): ____

DOES ANYTHING MAKE SYMPTOMS BETTER: ____

ALLERGIC HISTORY:
Please mark any that apply to you. This information is so that we can understand why you came to see us.

NOSE
- [ ] Itchy Nose
- [ ] Sneezing
- [ ] Runny Nose
- [ ] Stuffy Nose
- [ ] Decreased Smell
- [ ] Post Nasal Drainage
- [ ] Sinus Infection

EARS
- [ ] Itchy ears
- [ ] Blocked ears

THROAT
- [ ] Sore Throat
- [ ] Hoarseness

CHEST
- [ ] Wheeze
- [ ] Shortness of Breath
- [ ] Chest Tightness
- [ ] Chest Cough

GI
- [ ] Reflux
- [ ] Heartburn

EYES
- [ ] Itchy Eyes
- [ ] Watery Eyes
- [ ] Red Eyes

SKIN
- [ ] Hives
- [ ] Rash
- [ ] Eczema
- [ ] Itching
- [ ] Swelling

AGGRAVATING FACTORS
Please mark any factors that cause an increase in your symptoms:

	Mowed Grass		Hay/Dead Leaves		Paint		Detergents
	House Dust		Pollen		Perfumes		Windy Days
	Cats		Smoke		Fumes		Cold Fronts
	Dogs		Outside Dust		Hair Spray		Damp Weather
	Moldy/Musty Places		Odors		Soaps		Temperature Changes

Do you experience allergy symptoms seasonally or year-round? ( ) Seasonally ( ) Year round
If seasonally, please mark all that apply: ( ) Spring ( ) Summer ( ) Fall/Autumn ( ) Winter

HEADACHE:
Do you have headaches associated with your nasal & sinus symptoms? ( ) Yes ( ) No
Do you have a history of migraines? ( ) Yes ( ) No
If yes, are they associated with your sinus symptoms? ( ) Yes ( ) No

FOR PROVIDER USE ONLY:

______________________ Provider Signature

______________ Date

Chart #: ___________________ Date: ________

FOOD / INSECT STING REACTIONS:

Please list any food or insect sting reaction or side effect you currently have or have had at some point in life:

Cause	Type Reaction/ Side Effect			
	( ) Rash/Hives	( ) Swelling	( ) Itching	( ) Short of Breath
	( ) Rash/Hives	( ) Swelling	( ) Itching	( ) Short of Breath
	( ) Rash/Hives	( ) Swelling	( ) Itching	( ) Short of Breath
	( ) Rash/Hives	( ) Swelling	( ) Itching	( ) Short of Breath
	( ) Rash/Hives	( ) Swelling	( ) Itching	( ) Short of Breath

Other types of reactions/side effect you have experienced:____

____

TICKS

Have you ever been bitten by a tick? ( ) Yes ( ) No If so, when?____

Do you spend a lot of time outdoors? ( ) Yes ( ) No

STEROIDS

Have you received a steroid injection in the last six months? ( ) Yes ( ) No If so, when?______________________

Why did you receive a steroid injection? ____

PREVIOUS ALLERGY EVALUATION:

Have you seen an allergist before? ( ) Yes ( ) No If so, when?____

Have you been skin tested? ( ) Yes ( ) No

Have you ever been on allergy shots? ( ) Yes ( ) No If so, are you still taking them? ( ) Yes ( ) No

If so, approximately how long did you take them?__________ When did you quit? ______________________________

CURRENT MEDICATIONS:

Please list all current allergy medications, with dose, you are taking regularly to relieve your allergy symptoms:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Please list all other medications, with dose, you are taking and indicate why:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

List all medications or supplements you take occasionally, including dose (e.g., Tylenol, sleeping pill, etc): ___________________

____

____

DRUG ALLERGIES:

Please list all medications to which you are allergic:

Drug: ____ Reaction: ____

Drug: ____ Reaction: ____

Drug: ____ Reaction: ____

( ) Others. (Please list the drug and reaction below.)

Chart #: ____________________ Date: ________

MEDICAL HISTORY:

Please list all significant medical problems such as Diabetes, High Blood Pressure, Heart Disease, Stomach Ulcer, Glaucoma, Seizure Disorder, Thyroid Disease, etc.:

____
____
____
____
____
____

SURGICAL HISTORY & HOSPITALIZATIONS:

Please list all hospitalizations and surgeries in order of most recent first: Year

1. ____ ____________________
2. ____ ____________________
3. ____ ____________________
4. ____ ____________________
5. ____ ____________________

IMMUNIZATIONS:

Have you been vaccinated against pneumonia? ( ) Yes ( ) No If yes, when: ______________________

Have you been vaccinated for chicken pox? ( ) Yes ( ) No If yes, when: ______________________

Or have you had chicken pox? ( ) Yes ( ) No If yes, when: ______________________

Have you had a flu shot this year? ( ) Yes ( ) No If yes, when: ______________________

Are childhood immunizations up to date? ( ) Yes ( ) No

PATIENT RESIDENCE:

What is the age of your home? ( ) 0 – 10 years ( ) 11 – 15 years ( ) 16 – 20 years ( ) More than 20 years

How long have you lived at current residence? ( ) 1 year or less ( ) 1 – 5 years ( ) 6 – 10 years ( ) over 10 years

What type of heating/cooling system? Mark all that apply:

☐ Central/Forced Air	☐ Space Heating	☐ Gas	☐ Electric	☐ Oil/Kerosene
☐ Radiant Heat	☐ Wood burning	☐ Ceiling Fan	☐ Window Units	☐ Other

Please mark any of the following that are present in the patient bedroom:

☐ Feather Products on Bed	☐ Sleep with Stuffed Animals	☐ Carpet in Bedrooms	☐ Sleep with pets in bed	☐ Spring Mattress
☐ Foam Mattress	☐ Feather Pillows	☐ Vinyl covers on mattress	☐ Carpet	☐ Hardwood
☐ Tile flooring	☐ Linoleum/LVP/other vinyl flooring	☐ Drapes / heavy window coverings	☐ Houseplants	☐ Sleep with floor fan/ceiling fan on

If you have pets, what kind? Indoor: ____

Outdoor: ____

FAMILY HISTORY:

( ) Adopted/Family history is unknown.

Please mark any that apply to blood relatives.

	Hayfever	Asthma	Sinus Problems	Immune Deficiency	Cystic Fibrosis	Hives	Eczema	Food Allergy	Auto-immune Disease
Mother	( )	( )	( )	( )	( )	( )	( )	( )	( )
Father	( )	( )	( )	( )	( )	( )	( )	( )	( )
Siblings	( )	( )	( )	( )	( )	( )	( )	( )	( )
Children	( )	( )	( )	( )	( )	( )	( )	( )	( )
Other	( )	( )	( )	( )	( )	( )	( )	( )	( )

SOCIAL HISTORY:

How many people are living at home? ____

Marital Status (if patient minor/child, leave blank): ____

What are your favorite hobbies? ____

____

Employment

Where are you employed (or attend school)? ____

Job description? ____

Does anything at work or school bother your allergies? ____

Number of days missed from work/school per year because of allergy, sinus or asthma problems? _______________

If patient is a child, does he/she attend day care? ____

If yes, how many days per week? ____

TOBACCO USE / EXPOSURE:

Indicate any that are true for the patient:

- ☐ Current smoker
- ☐ Uses smokeless tobacco or nicotine patches
- ☐ Former Smoker
- ☐ Smokers in the home (smoke indoors)
- ☐ Nonsmoker
- ☐ Smokes in car, or parent smokes in car
- ☐ Uses Vape
- ☐ Vapes in car or inside home
- ☐ Chews tobacco

If Current or Former smoker, please complete next section:

How many years have you smoked? ____

How many packs per day? ____

Have you ever quit as long as 6 months? (please explain) ____

If you have smoked in the past, what year did you stop smoking? _________________________________

How many years did you smoke and how much? ____