ALLERGY, ASTHMA AND IMMUNOLOGY CENTER – NEW PATIENT QUESTIONNAIRE

www.allergyaic.com

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)* _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

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

_____

WHEN DID SYMPTOMS BEGIN: _____

HOW OFTEN DO THEY OCCUR: _____

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/Congestion
- ☐ 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

HEADACHE:

Do you have headaches associated with your nasal & sinus symptoms? ( ) Yes ( ) No

Do you have a history of migraines? ( ) Yes ( ) No

FOOD REACTION:

Please list any adverse reactions you have had to foods:

_____

_____

INSECT REACTION:

Please list any adverse reactions you have had to insects:

_____

_____

FOR PROVIDER USE ONLY:

_____ _____

Provider Signature Date

Chart #: _____ Date: _____

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

____ Hairspray ____ Damp Weather ____ Moldy/Musty Places ____Odors ____ Soaps ____ Temperature Changes

NONE OF THE ABOVE: _____

Do you experience allergy symptoms seasonally or year-round? ( ) Seasonally ( ) Year round

If seasonally, please mark all that apply: ( ) Spring ( ) Summer ( ) Fall/Autumn ( ) Winter

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? _____

ENVIRONMENTAL FACTORS:

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 ____ Radiant Heat ____ Ceiling Fan ____ Window Units

____ Wood Burning ____Gas ____ Electric ____ Oil/Kerosene

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

___ Feather Products on Bed ____ Sleep with Stuffed Animals ____ Carpet ____ Hardwood

PETS:

If you have pets, what kind? Indoor: _____

Outdoor: _____

Do your pets sleep in bed with you? ( ) Yes ( ) No

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? _____

Chart #: _____ Date: _____

CURRENT MEDICATIONS:

Please list all current **ALLERGY & ASTHMA** medications you are taking regularly to relieve your allergy symptoms:

Medication	Strength	How Taking:	Reason Taking/Diagnosis:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all **OTHER** medications you are taking:

Medication	Strength	How Taking:	Reason Taking/Diagnosis:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

____ Medication List Attached (See list)

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.)
___ No known drug allergies

MEDICAL HISTORY:

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

_____
_____
_____
_____
_____
_____

Chart #: _____ Date: _____

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

FAMILY HISTORY:

( ) Adopted/Family history is unknown.

Please mark any that apply to blood relatives.

	Hay Fever	Asthma	Sinus Problems	Immune Deficiency	Cystic Fibrosis	Hives	Eczema	Food Allergy	Auto-immune Disease
Father	( )	( )	( )	( )	( )	( )	( )	( )	( )
Mother	( )	( )	( )	( )	( )	( )	( )	( )	( )
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 ____ Former Smoker ____ Nonsmoker ____ Uses Vape ____ Uses smokeless tobacco or nicotine patches

____ Smokers/Vapers in the home (smoke indoors) ____ Smokes in car or parent smokes in car ____ 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? _____