ALLERGY ASTHMA AND ARTHRITIS ASSOCIATES, PC

NEW PATIENT QUESTIONNAIRE

*Please bring the completed form with you to your appointment *

PATIENT INFORMATION: Appointment Date:

Patient Name:_____ Date of Birth:_____

Referring Physician:_____ Primary Physician:_____

REASON FOR EVALUATION: *What are the issues you would like to discuss with our physician*

_____

_____

ALLERGY HISTORY: *Please describe ALL your allergy symptoms.*

Chest and Breathing Symptoms

YES	NO		Age of onset	Please circle the months your symptoms are most severe.
☐	☐	Asthma		J F M A M J J A S O N D
☐	☐	Wheezing		J F M A M J J A S O N D
☐	☐	Cough		J F M A M J J A S O N D
☐	☐	Chest tightness/pain		J F M A M J J A S O N D
☐	☐	Bronchitis/Pneumonia		J F M A M J J A S O N D

What triggers your symptoms or makes your symptoms worse?

_____

What makes your symptoms better?

_____

What other medications have you tried? And are there reasons why you liked or did not like them?

_____

Nose and Sinus Symptoms

YES	NO		Age of onset	Please circle the months your symptoms are most severe.
☐	☐	Runny Nose		J F M A M J J A S O N D
☐	☐	Post-nasal drip		J F M A M J J A S O N D
☐	☐	Sneezing		J F M A M J J A S O N D
☐	☐	Congestion		J F M A M J J A S O N D
☐	☐	Sinusitis		J F M A M J J A S O N D

What triggers your symptoms or makes your symptoms worse?

_____

What makes your symptoms better?

_____

What other medications have you tried? And are there reasons why you liked or did not like them?

_____

Eye Symptoms

YES	NO		Age of onset	Please circle the months your symptoms are most severe.
☐	☐	Itchy/swollen eyes		J F M A M J J A S O N D
☐	☐	Irritated burning eyes		J F M A M J J A S O N D
☐	☐	Dry eyes		J F M A M J J A S O N D
☐	☐	Teary eyes		J F M A M J J A S O N D

What triggers your symptoms or makes your symptoms worse?

_____

What makes your symptoms better?

_____

What other medications have you tried? And are there reasons why you liked or did not like them?

Name:_____ D.O.B:_____ Date:_____

Skin Symptoms

YES	NO		Age of onset	Please circle the months your symptoms are most severe.
☐	☐	Hives		J F M A M J J A S O N D
☐	☐	Eczema/atopic dermatitis		J F M A M J J A S O N D
☐	☐	Swollen lips/tongue		J F M A M J J A S O N D
☐	☐	Swollen face/hands/feet		J F M A M J J A S O N D

What triggers your symptoms or makes your symptoms worse?

What makes your symptoms better?

Recurrent Infections

YES	NO		Age of onset	Please list frequency of infections per year and antibiotic used
☐	☐	Ear infections		
☐	☐	Sinus infections		
☐	☐	Lung infections		
☐	☐	Skin infections (not acne)		
☐	☐	Meningitis		

Please describe other severe repeated infections if applicable.

Please describe in detail if you have had overnight hospitalizations for your infections.

Other Allergies

YES	NO		Age of onset	Please list dates of ALL reactions and symptoms
☐	☐	Medications		
☐	☐	Foods		
☐	☐	Insect Stings		
☐	☐	Latex		

Please describe any **other** allergic reactions you have experienced.

CURRENT MEDICATIONS: List ALL medications, doses, and times of day taken, including OTC and supplements.

Name:_____ D.O.B:_____ Date:_____

PREVIOUS ALLERGY EVALUATION AND TREATMENT: Please provide us with copies of the records, if available

Have you had any allergy skin tests before? ☐ Yes ☐ No Date:_____ Results:_____
Have you had allergy blood tests before? ☐ Yes ☐ No Date:_____ Results:_____
Have you received allergy immunotherapy before? ☐ Yes ☐ No Date:_____ Results:_____

IMMUNIZATION HISTORY: Please provide copies of vaccines if available

Have you experienced a serious reaction to a vaccine? ☐ Yes ☐ No Details if applicable:_____
Date of last Influenza vaccine and/or Pneumovax vaccine:_____

NEWBORN HISTORY: Applicable if patient is less than 18 years old

Was there any difficulty while the mother was pregnant with the patient? ☐ Yes ☐ No
How many weeks gestation was the patient born? _____ Was breathing assistance required at birth? ☐ Yes ☐ No
Did the patient go to the regular nursery or the newborn intensive care unit (NICU)?_____
Please describe **how long** the patient was **exclusively** breastfed. Also list **when** and **what type** of formula was introduced._____
When were solid foods started?_____

MEDICAL HISTORY: Have you ever had or do you currently have any of the following?

	Never	Current	Past		Never	Current	Past
High or low blood pressure				Migraine headaches			
Coronary artery disease/angina				Sinus headaches			
Heart murmur				Tension headaches			
Stroke				Epilepsy/seizures			
Thyroid disease				Glaucoma			
Liver disease				Cataracts			
Infectious hepatitis (liver infection)				Emphysema			
Kidney disease				Tuberculosis			
Bladder trouble				Rheumatoid arthritis			
Prostate trouble				Osteoarthritis/joint replacement			
Menstruation trouble				Lupus			
Stomach trouble or ulcers				Diabetes or elevated blood sugar			
Heartburn or esophageal reflux				Sexually transmitted disease			
Depression				HIV/AIDS			
Anxiety				Cancer (Please provide details)			

Please list any other medical diagnoses **not** listed above. Or if needed, please expand on any of the above diagnoses.

_____
_____
_____
_____
_____

HOSPITALIZATIONS: Please list ALL dates and reasons for hospitalizations.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name:_____ D.O.B:_____ Date:_____

SURGERIES: Please list ALL dates and reasons for surgeries.

_____
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY: Please list any diseases (especially allergies, asthma, swelling, eczema, etc)

	Age	Gender	Medical Diagnoses	If deceased, at what age?
Father				
Mother				
Siblings				
Children				

SOCIAL HISTORY:

Tobacco:

Do you smoke? ☐Yes ☐No, never ☐No, I quit _____ ago. Does anyone you live with smoke? ☐Yes ☐No

If you ever smoked, what was the highest number of cigarettes per day? _____ How long did you smoke? _____

If you now smoke, have you quit in the past? ☐Yes ☐No Are you considering quitting? ☐Yes ☐No

Are you regularly exposed to passive (second-hand) tobacco smoke? ☐Yes ☐No

Alcohol: Do you drink alcohol? ☐Yes ☐No If yes, how many drinks per week on average?_____

Hobbies: _____

Occupation and exposures: _____

Change of symptoms with travelling: _____

How many days have you missed from work/school because of your allergy symptoms in the past year? _____

ENVIRONMENTAL HISTORY:

Past & Current Residences – *Please list most current residence first.*

City, State Years Effect on symptoms (better, worse, no change)

_____
_____
_____

What type of dwelling do you currently live in? ☐Single family ☐Mobile ☐Townhouse ☐Condo ☐Apartment

How old is your current residence?_____ How long have you lived there? _____

Do you have a gas/woodburning stove/fireplace? _____ Neighborhood? ☐urban/city ☐rural/farm ☐suburban

How is your home heated? _____ How is your home cooled? _____

Carpeting: ☐None ☐Area rugs only ☐Wall to wall Carpet type (synthetic, wool...) _____

Are there any damp/musty or moldy rooms? ☐Yes ☐No Has your basement flooded in the past? ☐Yes ☐No

Do you have an ☐Air filter ☐Dehumidifier ☐Humidifier Do you have a down/feather comforter? _____

How old is your pillow?_____ check details: ☐Feather ☐Synthetic ☐Foam ☐Allergy-barrier encased

How old is your mattress? _____ check details: ☐Foam ☐Innerspring ☐Allergy-barrier encased

Please list any pets you own and how many of each (cats, dogs, horses, rabbits, hamster)

Indoor:_____

Outdoor:_____

Do you have mice? ☐Yes ☐No Do you have cockroaches? ☐Yes ☐No

_____ _____

Signature of Patient (or patient guardian) *Date* *Signature of Provider* *Date*