

AIR ALLERGY AND ASTHMA, PC

NEW PATIENT QUESTIONNAIRE

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

Patient Information:	Appointment Date: _____
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Patient Name: _____ Date of Birth: _____

Referring Physician: _____ Primary Physician: _____

Reason for Evaluation:	<i>What are the issues you would like to discuss with our physician</i>
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Allergy History:	<i>Please describe ALL your allergy symptoms.</i>
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YES	NO	<u>Chest and Breathing Symptoms</u>	Age of onset	<i>Please circle the months your symptoms are most severe.</i>
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____	J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	_____	J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Cough	_____	J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Chest tightness/pain	_____	J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	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?

YES	NO	<u>Nose and Sinus Symptoms</u>	Age of onset	<i>Please circle the months your symptoms are most severe.</i>
<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	_____	J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Post-nasal drip	_____	J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	_____	J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Congestion	_____	J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	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?

YES	NO	<u>Eye Symptoms</u>	Age of onset	<i>Please circle the months your symptoms are most severe.</i>
<input type="checkbox"/>	<input type="checkbox"/>	Itchy/swollen eyes	_____	J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Irritated burning eyes	_____	J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes	_____	J F M A M J J A S O N D
<input type="checkbox"/>	<input type="checkbox"/>	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: _____

YES NO Skin Symptoms Age of onset *Please circle the months your symptoms are most severe.*

- | | | | | |
|--------------------------|--------------------------|--------------------------|-------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hives | _____ | J F M A M J J A S O N D |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema/atopic dermatitis | _____ | J F M A M J J A S O N D |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen lips/tongue | _____ | J F M A M J J A S O N D |
| <input type="checkbox"/> | <input type="checkbox"/> | 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?

YES NO Recurrent Infections Age of onset *Please list frequency of infections per year and antibiotic used*

<input type="checkbox"/>	<input type="checkbox"/>	Ear infections		
<input type="checkbox"/>	<input type="checkbox"/>	Sinus infections		
<input type="checkbox"/>	<input type="checkbox"/>	Lung infections		
<input type="checkbox"/>	<input type="checkbox"/>	Skin infections (not acne)		
<input type="checkbox"/>	<input type="checkbox"/>	Meningitis		

Please describe other severe repeated infections if applicable.

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

YES NO Other Allergies Age of onset *Please list dates of ALL reactions and symptoms*

<input type="checkbox"/>	<input type="checkbox"/>	Medications		
<input type="checkbox"/>	<input type="checkbox"/>	Foods		
<input type="checkbox"/>	<input type="checkbox"/>	Insect Stings		
<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease/angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infectious hepatitis (liver infection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis/joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstruation trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach trouble or ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or elevated blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn or esophageal reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (Please provide details)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:	<i>Please list ALL dates and reasons for surgeries.</i>
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Family History:		<i>Please list any diseases (especially allergies, asthma, swelling, eczema, etc)</i>		
	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