The Allergy Group

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NEW PATIENT QUESTIONNAIRE

Name:_____ Age:_____ DOB:_____ Date:_____
Referred By: _____ Primary Care Provider:_____

The major problem you wish to discuss today is: _____

History of present illness:

1. What allergy problem(s) do you have? (please circle)

Runny/stuffy nose Sinusitis Insect Allergy Eye or ear problems Asthma
Eczema/Rash Drug Allergy Headache
Cough Hives or swelling Food Allergy Frequent Infections
Other_____

2. List ***ALL*** prescription and over-the-counter medications you are currently using (**Name & Dosage**):

1)_____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

What medications have you tried for your allergy problems in the past? _____
_____
Are you allergic to any medications? If so, list drug, type of reaction and when: _____
_____
_____

3. Symptoms (please check all that applies)
   a. **Eyes**: Itch___ Swell___ Burn___ Tear___ Discharge___ Dry___
   b. **Ears**: Itch___ Fullness___ Popping___ Decreased hearing___ Pain___ Ringing___
   c. **Nose**: Sneeze___ Itch___ Runs___ Stuffy___ Mouth breather___ Snoring___ Yellow/Green drainage___ Decreased smell___ Decreased taste___
   d. **Throat**: Itch___ Sore___ Post nasal drip___ Throat clearing___ Swelling___ Hoarseness___
   e. **Lungs**: Cough___ Phlegm___ History of Asthma___ Wheezing___ Chest tightness___ Shortness of breath with exercise___ **Heartburn**___
   f. **Head**: Headaches? Yes/No Migraines? Yes/No What part of head?_____ How often?_____
   g. **Skin**: Eczema___ Hives___ Swelling___ Rashes___ Where on the body?_____

2. Respiratory Allergies
   a. Age of onset of your allergies_____, and/or asthma_____.
   b. Do you have daily symptoms?_____
   c. Which seasons are your allergies or asthma worse? (circle) Spring/Summer/Fall/Winter/All Year
   d. Does any particular exposure make you worse? (please check all that applies)
      Weather changes___, Dampness__, Fragrances/Odors___, Smoke___, Dust___, Cosmetics/Aerosols___, Mold___, Cats/Dogs/Other animals___, Grass/Mowing___, Weeds___, Trees___, Exercise___, Anger/Stress___, Coughing/Laughing___, Colds/Respiratory infections___, Cold air___, Foods/Drinks___ (what? _____)
      Other:_____

e. Do you get sinus infections (yellow/green nasal drainage, pain etc..)? _____ How often?_____
How is it usually treated?_____

f. Have you had nose or sinus surgery? (when?)_____

g. Have you ever had ear tubes or a tonsillectomy? (when?)_____

h. Have you been told by a physician that you have nasal polyps?_____

i. Do you have aspirin or NSAID induced nasal symptoms &/or wheezing?_____

If you have Asthma:

a. Do you use a spacer device for inhalers?_____ Do you use a nebulizer?_____

b. Have you required maintenance inhalers? If so, which ones have you used? _____
_____

c. Have you every required steroid pills (prednisone, dosepak) or shots (cortisone) to control your allergies or asthma? If so, how many times? _____

d. Have you ever been hospitalized for your asthma?_____

e. How many times in the past 12 months have you been to the ER with asthma?_____

f. How many puffs per week of your quick relief inhaler (albuterol) do you use?_____

g. Do you wake up at night coughing or requiring your inhaler?_____

3. Insect Allergy
   a. Have you had a severe allergic reaction to a stinging insect? Yes/No
   b. Did it cause a large local reaction? ____ OR cause hives, itching, or swelling all over the body? ____

4. Food Allergy
   a. Please list all foods and reactions they cause:_____
   _____
   _____
   b. Have you had hives before? (when and for how long?) _____
   c. Do you have a history or currently suffer from eczema? _____
   d. Are you sensitive to latex or rubber products? (explain)_____

Previous Allergy Evaluation & Treatment:

1. Name of Allergist and city: _____
2. Were you tested for allergies by skin prick test or blood test? If so, when: _____
3. Have you ever received Allergy Shots? If so, when and for how long? _____

Past Medical History:

1. Medical Problems: (Please circle)

High Blood Pressure	Diabetes	Thyroid Problem	High Cholesterol	Heart Disease
Abnormal Chest x-ray	Sleep Apnea	Glaucoma	Stomach ulcer	Hiatal hernia
Heartburn/Reflux	Cancer	HIV/AIDS	Hepatitis	Positive TB test
Depression	Arthritis	Blood Transfusion	Kidney disease	Prostate

   Other:_____
2. Please list all surgical operations and hospitalizations that you have had: _____
   _____
3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results)_____
   _____
4. Are you up to date on all recommended vaccinations?_____
5. Do you receive yearly flu vaccines? When was last? _____
6. Have you received a pneumonia vaccine? When? _____

Family History: Please place an "X" in the appropriate box(es) below

	Hay Fever	Asthma	Eczema	Hives	Sinus	Diabetes	Cancer	Hypertension	Mental Illness
Father									
Mother									
Siblings									
Children									

Please list any other major medical condition(s) that runs in your family:_____
_____

Personal & Environmental History Circle/Fill in answers accordingly

1. Tobacco smoker? No Yes Former
    a. If Yes or former - How much and for how long (Cigs/packs per day and number of years smoked)?
    _____
2. Do you use recreational drugs? _____
3. Have you drank alcohol in the last year? No Yes
    a. How often? 1 x Mo 2-4 x Mo 2-3 x Wk 4 or more x Wk
    b. How many drinks per occasion? 1-2 3-4 5-6 7-9 10 or more
4. What type of pets do you have?_____How long have you had them? _____
5. Carpeting in your home? None Wall to wall Partially Bedrooms only How old is your carpet? _____
6. What type of mattress/bedding do you have? Standard Waterbed Feather Sleep Number
7. What is your occupation? _____
   Are you exposed to any toxic chemicals, noxious substances at work? _____
8. How long have you lived in your current home?_____ How long have you lived in the Treasure valley area? ____
9. Do your symptoms become better while on vacation or while living somewhere else? _____
10. What are your daily activities/hobbies? _____
11. Have you traveled outside the United States in the last 6 months? _____ Where? _____

Review of Systems: (Do you have any of the following? Please check)

General
___Weight loss
___Fevers
___Night sweats
___Loss of appetite
___Dry mouth
___Snoring
___Swollen lymph nodes

Eyes & Ears
___Dry eyes
___Change in vision
___Trouble hearing
___Ringing in ears

Skin
___Skin rashes
___Frequent skin infections
___Abnormal skin lesions

Neurological
___Weakness/clumsiness
___Tingling/numbness of extremities

Endocrine
___Cold/heat intolerance
___Frequent urination
___Increased thirst

Gastrointestinal
___Nausea/Vomiting
___Diarrhea
___Change in bowel habits
___Trouble swallowing
___Heartburn

Cardiovascular
___Chest pain
___Chest pain with exercise
___Calf pain with exercise
___Ankle Swelling

Psychological
___Fearful, anxious
___excessive worry
___Trouble sleeping
___Depression

Kidney
___Trouble starting urine
___Loss of urine with cough/sneeze
___Frequent nighttime urination

Musculoskeletal
___Painful swollen joints
___Muscle tenderness or pain
___Muscle weakness
___Abnormal bone density

Gynecological
___Excessive bleeding
___Changes in menstrual cycle
___Post-menopausal

Getting a yearly flu shot is the best way to prevent getting influenza. Influenza can be dangerous for people with allergies/asthma and other chronic diseases. We recommend a yearly flu shot for all our allergy patients who have no contraindications to this vaccine. Please ask us if you have any questions concerning the flu vaccine

Patient/Parent Signature_____
(Please type first and last name if electronic signature)

Medical Provider's Initials (indicates the form has been reviewed)_____Date_____