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Patient Name_____

Date of Birth_____

Appointment Date_____

NEW PATIENT QUESTIONNAIRE

I. **BRIEFLY DESCRIBE** the reason for your visit today. What do you hope to accomplish? _____

_____

How long have you had this problem? _____

How severe is this problem? (please rate on a scale of 1-5 with 5 being the most severe)_____

Does it interfere with your life? (work, school, recreation, sleep, etc.)_____

II. **ALLERGY SYMPTOMS:** Do you experience any of the following? Please check all that apply.

	NOSE:		**SINUSES:**		**CHEST:**
	Stuffy		Drainage down back of throat		Productive cough
	Sneezing		Throat clearing/sniffing		Bronchitis
	Itching		Hoarseness		Limited exercise
	Clear discharge		Bad breath/bad taste in mouth		(Child) falls behind others at play
	Colored discharge		Frequent infections		Awakened by chest symptoms
	Thick discharge		**EARS:**		**SKIN:**
	Mouth breathing		Itching		Rash
	Snoring		Full/popping		Hives
	Loss or decreased sense of smell		Painful		Eczema
	Nose bleeds		Ringing/hearing loss		Dry
	Itchy palate/back of throat		Frequent infections		Bumpy
	EYES:		**CHEST:**		Itching
	Red		Tightness		Sores
	Itchy		Wheezing		**OTHERS:**
	Watery		Wheezing/cough with exercise		Fatigue
	Dry/painful		Wheezing with colds/infections		Heartburn
	Dark circles/puffiness		Wheezing near animals		
	SINUSES:		Shortness of breath		
	Headache		Cough		
	Sore throat		Dry cough		

III. CAUSES AND TRIGGERS

Which of the following cause your symptoms or make them worse? Please check all that apply to you.

	Pollen		Indoor dust		Being indoors
	Cedar		Dusting		Being at home
	Being outdoors		Vacuuming		Being at work
	Doing yard work, gardening		Major cleaning		Heat
	Mowing the lawn		Remodeling		Hot weather
	Windy days		Construction		Cold
	Weather changes		Bring out Christmas decorations		Cold weather
	Wet weather		Bring out other stored things		Drafts
	Dry weather after rain		Running the heater—1st time in the fall		Air conditioning
	Dry weather				Air pollution
	Northers		Dogs		Outdoor smoke
			Cats		Tobacco smoke
	Mold or mildew		Other animals		Chemical fumes
	Being near hay				Cleaning agents
	Working with or contact with hay		Before getting out of bed		Insecticides
	Barns		After getting out of bed		Paint, varnish
	Damp rooms		Morning		Perfume
	Musty places		Afternoon		Cosmetics
	Visible mold		Evening		Soap
	Cleaning the garage		After getting in bed at night		Newspaper
	Raking leaves		In the middle of the night		Wool
	Eating cheese		Relaxing		Cotton lint
	Eating mushrooms		Exercise		Wood or sawdust
	Going to the circus		Sunlight		Food cooking
					Stress
	Respiratory infections		Other:		
	Colds				

IV. TIMING, DURATION AND SEVERITY

Please circle the worst months for your allergies:

January February March April May June July August September October November December

Are your allergies

___ strictly seasonal. The rest of the year I have no problems.
___ worse in certain seasons, but I have some milder symptoms throughout the year
___ constant. They don't change with the seasons.
___ coming and going throughout the year, not related to the seasons.
___ I'm not sure

Are they

___ mild
___ moderate
___ severe
___ rare
___frequent annoying
___constant
___getting worse
___ causing you to miss work
___causing you to miss school
___interfering with your life
___preventing normal activities
___I'm getting tired of them

How long have your symptoms been present?

___ all my life, as far back as I can remember
___ from _____ (age)
___ ever since _____(life event)
___ for_____(# years or months)
___ever since I moved here
___after I had been here ____years
___I had allergy/asthma as a child
___My allergies have changed

Please list where you were born, and the places you have lived, with approximate ages or dates of moves.

Where you lived	From (date or age)	To (date or age)

Where were you living when your allergies began?_____

Have your allergies changed as you moved from place to place? If so, please explain. _____

_____

V. HOME ENVIRONMENT

Do you live in a: ___House ___Apartment ___Condominium ___Mobile home ___Two story
How long have you lived there? _____years/months
Age of home? _____ _____years/months
Is it located on/near: __Water __Vacant land __Farm __Quarry __Stable
Heating system: __Central __Space heaters __Radiators`` __None
Cooling system: __Central air __Window units __Other:_____
Ceiling fans: __Yes __No
Type of flooring: __Carpet __Wood __Tile __Vinyl __Rugs
Your bedroom: __Carpeted __Rugs __Ceiling fan __Air filter __Fan
__Cluttered __Neat __Wallpaper __Wall hangings __Pets allowed__Stuffed animals
Your bed: __Innerspring __Waterbed __Other:_____ How old?___ __Allergy encasing
Your pillow: __Feather __Synthetic __Age:_____ __Allergy encasing
Your bedroom closet: __Only currently used clothing __Used for storage
Your bedroom windows: __Curtains __Draperies __Blinds
Living/family room: __Carpeted __Age of oldest piece of upholstered furniture: _____years
Do you have a musty or damp __Bathroom __Kitchen __Laundry room __Other room
Have you had a problem with flooding or a water leak? __Yes __No
Recent painting, remodeling or repairs? _____

VI. WORK ENVIRONMENT

What is your occupation? _____ **Where are you employed?_____**
How long have you worked there? _____ **Is it** __Carpeted __Tiled __Other
Is it air conditioned? __Yes __No **Is smoking permitted?** __Yes __No
Chemicals or strong odors? __Yes __No **If yes, please specify: _____ _____**
Recent painting, remodeling or repairs? __ Yes __No
Symptoms worse at work? __Yes __No **If yes, please specify: _____**
Missed work because of allergies? __Yes __No **If yes, how much time? _____**

VII. SCHOOL ENVIRONMENT

Do you attend school? __Yes __No **If yes, what grade level?__ _____**
Is your classroom __Carpeted __Tiled __"Portable"
Interfere with physical education? __Yes __No
Missed time from school because of allergies or asthma? __Yes __No _____days in last year

VIII. ANIMAL DANDER

How many pets do you have? __Dogs __Cats __Others: _____
Are you worse when you are near any of them? __Yes __No **Which ones?** _____
Do you have problems if you touch any of them? __Yes __No **Which ones?** _____
Have any other animals ever bothered your allergies? __Yes __No
What type? __Dogs __Cats __Horses __Others:_____
Please list your pets/animals:
Type of animal (Name if appropriate) Age (yrs) In house? In bedroom? In your bed?

Type of animal (name if appropriate)	# years you have had it	Allowed in the house?	In the bedroom?	In your bed?

IX. FOODS

Have you ever had any systemic symptoms (itching, hives, wheezing, shortness of breath, throat swelling, difficulty swallowing, dizziness, fainting, shock) after eating foods or liquids? __Yes __No
If yes, specify: _____

_____

Do you have significant intestinal symptoms (nausea, vomiting, cramps, pain, diarrhea) after ingestion of food or liquid? __Yes __No **If yes, specify:** _____

_____

Have any special allergy diets been tried in the past?__Yes__No **If so, did they help?** __Yes __No
Please provide details: _____

_____

X. INSECT STING REACTIONS

Have you ever had systemic symptoms (hives, wheezing, shortness of breath, dizziness, fainting) after an insect sting? __Yes __No **If yes, explain:** _____

_____

Have you ever had a large local reaction (large swelling lasting several days) or other unusual reaction after an insect sting? __Yes __No **If yes, explain:** _____

XI. DRUG REACTIONS

Have you ever had an adverse reaction to a medication? Please check all that apply.

	Penicillin		Cortisone/steroids		Flu shot		Herbs
	Sulfa		Hormones		Antihistamines		Others
	Other antibiotics		Aspirin		Decongestants		
	Antibiotic ointment		Arthritis/pain meds		Local anesthetics		
	Other skin cream		Nose drops		Narcotics		
	Eye drops		Laxatives		Cough syrup		
	Vitamins		Tetanus shot		X-ray dye		

XII. RASHES FROM CONTACT

Have you ever had a rash from contact with:

	Poison ivy/oak		Soap		Crafts		Sawdust
	Other plants		Cosmetics		Fabric softener		Others
	Work		New clothing		Household cleaners		
	Hobbies		Metals		Wool		

XIII. ECZEMA

Have you ever had a problem with tiny, itchy bumps that would stay for days or weeks? __Yes __No
If so, when? _____
Are you having that problem now? __Yes __No
Where does it occur on your body? __Elbows __Knees __Hands __Feet
__All over __Other: _____
When does it occur? _____
Have you found anything that makes it worse? _____:_____

XIV. HIVES

Have you ever had a problem with itchy bumps that come and go in minutes to hours to possibly a day or two? __Yes __No **If so, when?** _____
Are you having that problem now? __Yes __No **How long do they last for?** _____
How big do they get? _____ **Do they burn?** __Yes __No
Do they leave a bruise? __Yes__No **Are they painful?** __Yes __No
Have they ever involved: __Tongue-swelling __Difficulty swallowing __Difficulty breathing
Please check those that apply:

	Foreign travel		Recent antibiotics		Worse with heat		Grocery worker
	Diarrhea		Recent surgery		Worse with exercise		Worse after touch food
	Weight change		Recent infection		Worse with cold		Other cause suspected:
	Blood in stool		New medication		Worse swimming		
	Other bleeding		New food		Worse with vibration		

XV. HABITS

Sleep: __Hours/day (average) __Sleep problems __Often poorly rested __Snore
__Stop breathing while sleeping __Fall asleep while driving
Smoking:__Yes__No __Packs cigarettes/day __Cigars __Pipe __Other
__ Ex-smoker When did you quit? _____ Why? _____
__ Other smokers in house? __Yes __No Who? _____
Alcohol: __Yes __No Amount: _____
Exercise:__Yes __No How often? _____
Has your weight changed in the last year? __Yes __No

XVI. HOBBIES AND ACTIVITIES Check means you do it. Circle your problem activities.

	Golf		Gardening		Camping		Hiking
	Horseback riding		Bicycling		Jogging/running		Farming/ranching
	Hunting		Fishing		Snow skiing		Water skiing
	Swimming		Cooking		Painting		Knitting
	Metal work		Wood working				

XVII. PAST ALLERGY EVALUATION AND TREATMENT

Have you ever seen an allergist? __Yes __No **If so, allergist's name and date:** _____
Have you had allergy skin testing? __Yes __No **Blood tests?** __Yes __No **Other tests?** __Yes __No
If so, dates and results, if known: _____
Have you received allergy injections? __Yes__No **If yes, when:** _____
Did the allergy injections help? __Yes __No **Details:** _____
Have you ever experienced an adverse reaction to an allergy injection? __Yes __No
If yes, please give details:_____
Have you ever had any other type of allergy treatment? __Yes __No
If yes, please give details: _____
Have you had sinus X-rays or CT scan? __Yes __No **When?** _____
Results: _____
When was your last chest X-ray? _____ **Where?** _____
Results: _____

XVIII. PAST MEDICAL HISTORY Have you ever had any of the following?

	Measles		Hernia		Polio		Anemia
	Mumps		Kidney disease		Glaucoma		Ulcer
	Chickenpox		Thyroid disease		Blood transfusion		Reflux
	Whooping cough		High blood pressure		Heart attack		Hemorrhoids
	Scarlet fever		Low blood pressure		Angina		Venereal disease
	Diphtheria		Bladder infections		Irregular heartbeat		Bleeding tendency
	Smallpox		Epilepsy		Palpitations		
	Pneumonia		Migraine		Mitral valve prolapse		
	Rheumatic fever		Tuberculosis		Stroke		
	Heart disease		BCG		AIDS or HIV+		
	Arthritis		Diabetes		Infectious mono		
	Back trouble		Cancer		Bronchitis		

Previous hospitalizations/surgeries/serious illnesses/pregnancies:

Event	When?	Hospital, city, state

If the patient is a child, please complete the following:
Place of birth _____ **Age of mother at birth** _____
Was pregnancy/labor/delivery normal?__Yes__No **If no, please give details:** _____
Birth weight _____ **Breast-fed? Formula? Well-tolerated?** __Yes __No
Has child reached normal growth milestones? __Yes __No
If no, please specify: _____
Your relationship to child: _____

XIX. SOCIAL HISTORY

Marital status: __Single __Married __Separated __Divorced __Widowed
What was the last grade of school you completed? _____

XX. FAMILY MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings:			
Children:			

Who in your family has allergies? _____ **Asthma** _____
Skin problems _____ **Food allergy** _____

XXI. REVIEW OF SYSTEMS Please indicate any past history of the following:

	Constitutional Symptoms		**Mouth/Throat**		Shortness of breath with walking
	Good general health lately		Mouth sores		Wheezing
	Recent weight change		Bleeding gums		
	Fever		Bad breath or bad taste		**Gastrointestinal**
	Fatigue		Sore throat		Loss of appetite
	Headaches		Voice change		Change in bowel movements
			Swollen glands in neck		Nausea or vomiting
	Eyes				Frequent diarrhea
	Eye disease or injury		**Cardiovascular**		Painful bowel movements
	Wear glasses/contact lenses		Heart trouble		Constipation
	Blurred or double vision		Chest pain		Rectal bleeding, blood in stool
			Shortness of breath with lying flat		Tarry stools
	Ears/Nose		Swelling of feet, ankles, or hands		Abdominal pain
	Hearing loss or ringing				
	Earaches		**Respiratory**		
	Drainage		Chronic or frequent cough		
	Sinus problems		Spitting up blood		
	Nose bleeds		Shortness of breath at rest		
	Genitourinary		**Integumentary**		**Psychiatric**
	Frequent ruination		Rash or itching		Memory loss or confusion
	Burning or painful urination		Change in skin color		Nervousness
	Blood in urine		Change in hair or nails		Anxiety
	Change in force of stream		Brittle nails		Depression
	Incontinence or dribbling		Insomnia		
	Kidney stones				
	Sexual difficulty		Breast pain		**Endocrine**
	Male—testicle pain		Breast lump		Glandular or hormone problems
	Female—pain with periods		Breast discharge		Excessive thirst or urination
	Female—irregular periods				Heat or cold intolerance
	Female—vaginal discharge		**Neurological**		Skin becoming drier
	Female--# of pregnancies		Frequent or recurring headaches		Change in hat or glove size
	Female--# of miscarriages		Light headed or dizzy		
	Female—date of last pap smear:		Convulsions or seizures		**Hematologic**
			Numbness or tingling		Slow to heal after cuts
	Musculoskeletal		Tremors		Bleeding or bruising tendency
	Joint pain		Paralysis		Anemia
	Joint stiffness or swelling		Head injury		Phlebitis
	Weakness of muscles or joints		Decrease in sense of smell		Past transfusion
	Muscle pain or cramps				Enlarged lymph nodes/glands
	Back pain				
	Cold extremities				
	Difficulty walking				

_____ _____

Signature of patient, parent or guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date