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ALLERGY-CHILDREN AND ADULT

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New Patient Questionnaire

PATIENT NAME: _____ AGE: ____ DOB: _____ (F) (M)

RACE OR ETHNIC GROUP: ( ) American Indian or Alaskan Native ( ) Asian or Pacific Islander ( ) Black

***multi race individuals may check all that apply** ( ) Hispanic / Latino ( ) White ( ) I decline to respond

REFERRING PROVIDER / PRIMARY (If any) : _____

CHIEF COMPLAINT: (Please briefly describe your symptoms in the space below)

_____

_____

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 _____
Coryza _____
Sinus Infection ____
Postnasal Drip ____
Headache ____
Decreased Smell ____

EARS

Itchy ears ____
Blocked ears ____

THROAT

Sore Throat ____
Hoarseness ____

CHEST

Wheezing ___ Chest cough _____
Shortness of breath ___
Tightness in chest ____

EYES

Itchy eyes ___ Red eyes ___
Watery eyes ___

SKIN

Hives ___ Itching ____
Rash ____ Swelling _____
Eczema ___

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

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

If yes, are they associated with your symptoms? ( ) Yes ( ) No

INSECT STING:

Have you ever had a severe reaction to a bee sting? ( ) Yes ( ) No

If yes, please explain: _____

Have you ever had a severe reaction to a fire ant sting? ( ) Yes ( ) No

If yes, please explain: _____

FOOD: Please describe any food reactions/ sensitivities: _____

LATEX: Do you have exposure to latex (rubber) products on a regular basis? ( ) Yes ( ) No

Has latex exposure at medical or dental office caused nasal/ lung symptoms or hoes/ excessive swelling? ( ) Yes ( ) No

DRUG ALLERGIES: List all medications which you are allergic:

Penicillin ( ) Yes ( ) No
Sulfa ( ) Yes ( ) No
Aspirin ( ) Yes ( ) No
Other (please list): _____

IMMUNIZATION:

Have you been vaccinated against, pneumonia? ( ) Yes ( ) No If yes, When: _____
Have you been vaccinated for chicken pox? ( ) Yes ( ) No If yes, When: _____
Have you had Chicken pox? ( ) Yes ( ) No If yes, When: _____
Have you had a flu shot this year? ( ) Yes ( ) No If yes, When: _____
Are child immunizations up to date? ( ) Yes ( ) No If yes, When: _____

ALLERGY SURVEY: *Please mark any factors that cause an increase in your symptoms:*

ALLERGEN		**IRRITANTS**		**WEATHER CHANGES**	
Mowed grass	○	Smoke	○	Windy days	○
House Dust	○	Outside dust	○	Col Fronts	○
Cats	○	Odors	○	Temperature Changes	○
Dogs	○	Paint	○	Damp Weather	○
Moldy/musty places	○	Perfumes	○		
Hay/ dead leaves	○	Fumes	○		
Pollen	○	Hair Spray	○		
		Soaps	○		
		Detergents	○		

Do you experience allergy symptoms seasonally or year-round? ( ) seasonally ( ) Year round
If seasonal, please mark all that apply: ( ) Spring ( ) Summer ( ) Fall/ Autumn ( )Winter

What type of heating/ cooling system do you have?
Forced Air (central) _____ Radiant _____ Wood _____ Kerosene/Oil _____ Ceiling Fan _____
Do you use any feather products on your bed? ( ) Yes ( ) No
Do you sleep with stuffed animals? ( ) Yes ( ) No
Do you have carpet in your bedroom? ( ) Yes ( ) No
Do you have pets? ( ) Yes ( ) No
If yes, what kind? _____
Indoor: _____
Outdoor: _____
Do your pets sleep with you? ( ) Yes ( ) No

REVIEW OF SYSTEMS:

Please mark any that apply to you. This information is so that we can better understand your general health and well- being.

GENERAL		**ENDOCRINE**		**MUSCULOSKELETAL**		**CARDIOVASCULAR**	
Appetite change	(_)	Heath/ cold sensitive	(_)	Joint pain	(_)	Chest pain	(_)
Weight change	(_)	Excessive thirst	(_)	Joint swelling	(_)	Palpitations	(_)
Fatigue	(_)	Excessive hunger	(_)	Muscle pain	(_)		
Fever	(_)	Excessive urination	(_)	Weakness	(_)	**GASTROINTESTINAL**	
Chills	(_)	Burning in feet	(_)	Backache	(_)	Heartburn	(_)
Sweats	(_)					Reflux	(_)

PSYCHIATRIC		**GENITOURINARY**		**NEUROLOGICAL**	
Mood disturbance	(_)	Urinary difficulty	(_)	Dizziness	(_)

PREVIOUS ALLERGY EVALUATION:

Have you seen an allergist before? ( ) Yes ( ) No If so, when? _____

Do you have skin test results? ( ) Yes ( ) No (If do, please bring skin test results to the office)

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 discontinue? _____

MEDICAL HISTORY:

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

_____
_____
_____
_____

SURGICAL HISTORY & HOSPITALIZATION:

Please list all hospitalizations and surgeries in order of most recent first:

1. _____ YEAR: _____
2. _____ YEAR: _____
3. _____ YEAR: _____
4. _____ YEAR: _____

FAMILY HISSTORY: Please mark all that apply to blood relatives.

	Hay fever	Asthma	Sinus Infection	Immune Deficiency	Cystic Fibrosis	Hives	Eczema	Food Allergy	Auto Immune Disease
Mother	(_)	(_)	(_)	(_)	(_)	(_)	(_)	(_)	(_)
Father	(_)	(_)	(_)	(_)	(_)	(_)	(_)	(_)	(_)
Siblings	(_)	(_)	(_)	(_)	(_)	(_)	(_)	(_)	(_)
Children	(_)	(_)	(_)	(_)	(_)	(_)	(_)	(_)	(_)
Other	(_)	(_)	(_)	(_)	(_)	(_)	(_)	(_)	(_)

SOCIAL HISTORY:

How many people are living at home? _____

Smoking History:

Do you currently smoke? ( ) Yes ( ) No Have you ever smoked? ( ) Yes ( ) No
How many years have you smoked? _____
How many packs per day? _____
Have you ever quit for as long as 6 months? _____
If you have smoked in the past, what year did you stop smoking? _____
How many years have you smoke and how much? _____

RECREATION:

Please list your favorite hobbies: _____

Employment

Where are you employed (or attend school?) _____

_____

Job description? _____

Anything at work or school bother your allergies? _____

_____

Number of days missed from school/work per year because of allergy, sinus, or asthma problems? _____

_____

If the patient is a child, does he/she attend day care? _____

If yes, how many days per week? _____