Allergy, Asthma, and Immunology Innovations

New Patient Questionnaire

Instructions: Please print and complete within three (3) days of your appointment.

Name: **Date of Birth:**

Appointment Date:

What is the reason for your visit?

_____

_____

NOSE AND EYES:

Please mark which season(s) during which you have been experiencing the following symptoms:

	Spring	Summer	Fall	Winter	Year-round
Runny nose					
Stuffy nose					
Post-nasal drainage					
Itchy nose					
Sneezing					
Morning sore throat					
Sinus/facial pressure					
Watery eyes					
Red eyes					
Itchy eyes					

Please circle all that apply:

Do your symptoms improve on vacation? Yes No

Is your nasal congestion/stuffiness worse on the: Left Right Equal N/A

Please circle any triggers you have noticed for the above symptoms:

Irritants: Detergents/soap Cooking odors Perfumes/strong odors Smoke

House dust: Dusting Vacuuming

Molds: Cutting grass Raking leaves Basements

Pets/animals: Dogs Cats Other: _____

Weather: Hot Cold Humid Damp Weather changes

Other (e.g. medications, workplace): _____

SINUSES:

How often do you have sinus infections? _____

What symptoms do you have with a sinus infection (circle all that apply)?

Decreased sense of smell or taste Bad breath

Facial pressure Green/yellow drainage

Any history of sinus surgery? _____

LUNGS:

Have you been diagnosed with asthma? _____

If yes, when/how long ago? _____

Do you take any asthma medications? If so, what? _____

Have you ever been hospitalized for your asthma? _____

In the past twelve months:

- Have you seen a doctor for your asthma? _____
- Have you been to the emergency room for your asthma? _____
- Have you taken oral steroids (prednisone, Medrol dose pack) for your asthma? _____

Please circle any triggers for asthma that you have noticed:

Weather changes Colds/infections Allergies Medications

Exercise Smoke Strong smells

If you have asthma, please answer the following questions:

1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?

									SCORE
All of the time	1	Most of the time	2	Some of the time	3	A little of the time	4	None of the time	5	

2. During the past **4 weeks**, how often have you had shortness of breath?

More than once a day	1	Once a day	2	3 to 6 times a week	3	Once or twice a week	4	Not at all	5	

3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week	1	2 or 3 nights a week	2	Once a week	3	Once or twice	4	Not at all	5	

4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times per day	1	1 or 2 times per day	2	2 or 3 times per week	3	Once a week or less	4	Not at all	5	

5. How would you rate your **asthma** control during the **past 4 weeks**?

Not controlled at all	1	Poorly controlled	2	Somewhat controlled	3	Well controlled	4	Completely controlled	5	

TOTAL

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SKIN:

Any history of eczema? _____

If so, where? _____

How do/did you treat it? _____

Any history of hives?

If so, where? _____

How often? _____

How long do individual hives last? _____

Any associated symptoms? _____

How do/did you treat it? _____

Any other skin conditions?

_____

OTHER ALLERGIES:

Adverse food reactions:

Food	Age/year	Symptoms

Did you require emergency treatment for any of the above reactions? _____

Adverse drug reactions:

Drug	Age/year	Symptoms

Did you require emergency treatment for any of the above reactions? _____

Any history of venom (bee or wasp sting) allergy? _____

If so, please describe: _____

_____

Any history of latex (gloves, condoms, balloons, etc.) allergy? _____

If so, please describe: _____

_____

INFECTION HISTORY:

Please note approximately how many times you have had the following infections:

Pneumonia		Bronchiolitis/RSV infection	
Bronchitis		Sinusitis/Sinus infection	
Croup		Ear infection	
Strep throat/Pharyngitis		Influenza	
Varicella/Chicken pox		Zoster/Shingles	
Cellulitis		Abscess/Boil	
Fungal skin infection		Fungal nail infection	

Have you ever had to be hospitalized for IV antibiotics? _____

FAMILY HISTORY:

Have any family members have any of the following (please state which family member):

Asthma: _____ Environmental allergies: _____

Eczema: _____ Chronic hives: _____

Thyroid disease: _____ Rheumatoid arthritis: _____

Lupus: _____ Other autoimmune: _____

Leukemia/lymphoma: _____ Immune deficiency: _____

SOCIAL HISTORY:

Occupation: _____

Where do you live (please circle)? House Apartment Mobile home Other: _____

How long have you lived there? _____

What kind of A/C? Central Window units Other: _____

What kind of heating? Central Baseboard Radiator Fireplace Other: _____

Please describe your basement: Finished Unfinished Dry Damp None

Please describe your bedroom: Carpet Hard surface Blinds on windows Stuffed animals

Dust mite covers on pillows/mattress

Do you have any pets? Dog Cat Bird Rodent Reptile Other: _____

Do you/have you ever smoked or used tobacco or similar products? Current user Former user Never

If previously, how long ago did you quit? _____

If yes, please circle: Cigarettes Cigars Chewing Vaping

HEALTHCARE MAINTENANCE:

Are there any vaccines you are due for that you haven't received? _____

Did you get a flu shot last/this flu season? _____

PLEASE BRING ALL MEDICATIONS YOU ARE TAKING WITH YOU, OR A COMPLETE MEDICATION LIST INCLUDING DOSAGES/FREQUENCIES OF ALL MEDICATIONS.