Chart #: _____
Date: _____

The Allergy, Asthma & Sinus Center

New Patient Questionnaire

PATIENT NAME: _____

AGE: _____ **DOB:** _____ **REFERRING PROVIDER (If any):** _____

GENDER: ( ) Male ( ) Female **MARITAL STATUS:** ( ) Single ( ) Married ( ) Divorced ( ) Widowed

RACE OR ETHNIC GROUP: ( ) American Indian or Alaskan Native ( ) Asian or Pacific Islander ( ) Black
(For medical use only) ( ) Hispanic/Latino ( ) White ( ) I decline to respond
Multi-race individuals may check all that apply

PHARMACY: (Please list pharmacy name and location) _____

CHIEF COMPLAINT: (Please briefly describe your symptoms in the space provided 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 _____
Stuffy Nose _____
Coryza _____
Decreased Smell _____
Post Nasal Drainage _____
Headache _____
Sinus Infection _____

THROAT

Sore Throat _____
Hoarseness _____

EYES

Itchy eyes _____
Red eyes _____
Watery eyes _____

EARS

Itchy ears _____
Blocked ears _____

CHEST

Wheeze _____
Shortness of breath _____
Tightness in chest _____
Chest cough _____

SKIN

Hives _____
Rash _____
Eczema _____
Itching _____
Swelling _____

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 sinus 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: _____

FOODS: 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 a medical or dental office caused nasal/lung symptoms or hives/excessive swelling? ( ) Yes ( ) No

FOR OFFICE USE ONLY:

_____ Provider Signature

_____ Date

Patient Name: _____ **Chart #:** _____ **Date:**_____

IMMUNIZATIONS:

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

ALLERGY SURVEY:

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

ALLERGENS

Mowed grass _____
House Dust _____
Cats _____
Dogs _____
Moldy/musty places _____
Hay/dead leaves _____
Pollen _____

IRRITANTS

Smoke _____
Outside dust _____
Odors _____
Paint _____
Perfumes _____
Fumes _____
Hair spray _____
Soaps _____
Detergents _____

WEATHER CHANGES

Windy days _____
Cold Fronts _____
Temperature Changes _____
Damp Weather _____

Do you experience allergy symptoms seasonally or year round? ( ) Seasonally ( ) Year round
If seasonally, 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

Appetite change _____
Weight change _____
Fatigue _____
Fever _____
Chills _____
Sweats _____

CARDIOVASCULAR

Chest pain _____
Palpitations _____

GENITOURINARY

Urinary difficulty _____

MUSCULOSKELETAL

Joint pain _____
Joint swelling _____
Muscle pain _____
Weakness _____
Backache _____

NEUROLOGICAL

Dizziness _____

PSYCHIATRIC

Mood disturbance _____

ENDOCRINE

Heat/cold sensitive ____
Excessive thirst ____
Excessive hunger ____
Excessive urination ____
Burning in feet ____

GASTROINTESTINAL

Heartburn ____
Reflux ____

FOR OFFICE USE ONLY:
Provider told pt. to discuss any abnormals with PCP _____

Patient Name: _____ **Chart #:** _____ **Date:**_____

PREVIOUS ALLERGY EVALUATION:

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

Do you have skin test results? ( ) Yes ( ) No (If so, please bring skin test results to 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 quit? _____

CURRENT MEDICATION:

Please list all current medications you are taking to relieve your allergy symptoms:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list all other medications you are taking regularly:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List all medications you take occasionally (e.g., Tylenol, sleeping pill, etc):_____
_____
_____

DRUG ALLERGIES:

Please list all medications to which you are allergic:

1. Penicillin ( ) Yes ( ) No
2. Sulfa ( ) Yes ( ) No
3. Aspirin ( ) Yes ( ) No
4. Other (please list): _____
   _____

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 & HOSPITALIZATIONS:

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

		YEAR:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

Patient Name: _____ **Chart #:** _____ **Date:**_____

FAMILY HISTORY:

Please mark any that apply to blood relatives.

	Hayfever	Asthma	Sinus Problems	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 as long as 6 months? (please explain) _____
If you have smoked in the past, what year did you stop smoking? _____
How many years did 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 work/school per year because of allergy, sinus or asthma problems? _____

If patient is a child, does he/she attend day care? _____
If yes, how many days per week? _____