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.

<table>
<thead>
<tr>
<th>NOSE</th>
<th>THROAT</th>
<th>EYES</th>
<th>EARS</th>
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</thead>
<tbody>
<tr>
<td>Itchy Nose</td>
<td>Sore Throat</td>
<td>Itchy eyes</td>
<td>Itchy ears</td>
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<tr>
<td>Sneezing</td>
<td>Hoarseness</td>
<td>Red eyes</td>
<td>Blocked ears</td>
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<tr>
<td>Runny Nose</td>
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<td>Watery eyes</td>
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<tr>
<td>Stuffy Nose</td>
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<td>Coryza</td>
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<td>Decreased Smell</td>
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<td>Post Nasal Drainage</td>
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<tr>
<td>Headache</td>
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<tr>
<td>Sinus Infection</td>
<td>Wheeze</td>
<td>Hives</td>
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<td></td>
<td>Shortness of breath</td>
<td>Rash</td>
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<td></td>
<td>Tightness in chest</td>
<td>Eczema</td>
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<td></td>
<td>Chest cough</td>
<td>Itching</td>
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<td></td>
<td></td>
<td>Swelling</td>
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CHEST

Chest cough

SKIN

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.

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<th>FOODS</th>
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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	

ECWQ  9.5.17
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 IRRITANTS WEATHER CHANGES
Mowed grass ______ Smoke ______ Windy days ______
House Dust ______ Outside dust ______ Cold Fronts ______
Cats ______ Odors ______ Temperature Changes ______
Dogs ______ Paint ______ Damp Weather ______
Moldy/musty places ______ Perfumes ______
Hay/dead leaves ______ Fumes ______
Pollen ______ Hair spray ______

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 CARdiovascular GENITOURINARY MUSCULOSKELETAL
Appetite change ______ Chest pain ______ Urinary difficulty ______ Joint pain ______
Weight change ______ Palpitations ______
Fatigue ______
Fever ______
Chills ______
Sweats ______

NEUROLOGICAL PSYCHiATRIC ENDOCRINE GASTROINTESTINAL
Dizziness ______ Mood disturbance ______ Heat/cold sensitive ______ Heartburn ______
Excessive thirst ______
Excessive hunger ______ Reflux ______
Excessive urination ______
Burning in feet ______

FOR OFFICE USE ONLY:
Provider told pt. to discuss any abnormalities with PCP ______

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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. __________________________________ 1. ________________________________________
2. __________________________________ 2. ________________________________________
3. __________________________________ 3. ________________________________________
4. __________________________________ 4. ________________________________________
5. __________________________________ 5. ________________________________________
6. __________________________________ 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:
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
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SURGICAL HISTORY & HOSPITALIZATIONS:
Please list all hospitalizations and surgeries in order of most recent first:
1. ______________________________________________________________ ___________________________
2. ______________________________________________________________ ___________________________
3. ______________________________________________________________ ___________________________
4. ______________________________________________________________ ___________________________
5. ______________________________________________________________ ___________________________
6. ______________________________________________________________ ___________________________
7. ______________________________________________________________ ___________________________
8. ______________________________________________________________ ___________________________
FAMILY HISTORY:
Please mark any that apply to blood relatives.

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<th>Hayfever</th>
<th>Asthma</th>
<th>Sinus Problems</th>
<th>Immune Deficiency</th>
<th>Cystic Fibrosis</th>
<th>Hives</th>
<th>Eczema</th>
<th>Food Allergy</th>
<th>Auto-Immune Disease</th>
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<td>Mother</td>
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<td>Children</td>
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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? __________________________