ALLERGY/IMMUNOLOGY NEW PATIENT QUESTIONNAIRE

Name:_____ Age:_____ DOB:_____
Date: _____ MRN: _____
Referred by:_____
Primary Care Provider: _____
Form completed by (if other than patient):_____

HISTORY OF PRESENT ILLNESS

What allergy problem(s) do you have? (please circle)

Runny/stuffy nose	Sinusitis	Insect Allergy	Eye or ear problems
Asthma	Eczema	Drug Allergy	Headache
Cough	Hives or swelling	Food Allergy	Frequent Infections
Contact dermatitis	Latex Allergy	Rash	Other: _____

What is the major problem you wish to discuss today?

_____

List all prescription and over-the-counter medications you are currently using (Name & Dosage):

1) _____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

What medications have you tried for your allergy problems in the past?

_____

Are you allergic to any medications? If so, list drug, type of reaction, and when the reaction occurred:

_____
_____

Symptoms (please check all that apply):

a. **Eyes**: □Itch □Swell □Burn □Tear □Discharge □Dry
b. **Ears**: □Itch □Fullness □Popping □Decreased hearing □Pain □Ringing
c. **Nose**: □Sneeze □Itch □Runs □Stuffy □Mouth breather □Snoring □Yellow/green drainage □Decreased sense of smell ☐Decreased taste
d. **Throat**: □Itch □Sore □Post-nasal drip □Throat clearing □Swelling □Hoarseness
e. **Lungs**: □Cough □Phlegm □History of Asthma □Wheezing □Chest tightness □Shortness of breath with exercise □Heartburn/reflux
f. **Head**: □Headaches □Migraines What part of head?_____ How often?_____
g. **Skin**: □Eczema □Hives □Swelling □Rashes Where on the body?_____

Respiratory Allergies

a. Age of onset of your allergies_____, and/or asthma_____
b. Do you have daily symptoms?_____
c. Which seasons are your allergies or asthma worse? (circle): Spring/Summer/Fall/Winter/All Year
d. Does any particular exposure make you worse? (please check all that applies)
□ Weather changes □ Dampness □ Fragrances/Odors □ Smoke □Dust
□Cosmetics/Aerosols □Mold □ Cats/Dogs/Other animals ☐Grass/Mowing □ Weeds □ Trees
□ Exercise □ Anger/Stress □ Coughing/Laughing □Colds/Respiratory infections □Cold air
Other:_____
e. Do you get sinus infections (yellow/green nasal drainage, pain etc..)?_____How often?_____
How is it usually treated?_____

f. Have you had nose or sinus surgery? (when?)_____
g. Have you ever had ear tubes or a tonsillectomy? (when?)_____
h. Have you been told by a physician that you have nasal polyps?_____
i. Do you have aspirin or NSAID induced nasal symptoms &/or wheezing?_____

Asthma: (Skip if no history of asthma)

j. Do you use a spacer device for inhalers?_____Do you use a nebulizer?_____
k. Have you required maintenance (daily) inhalers? If so, which ones have you used? _____
l. Have you every required steroid pills (prednisone) or shots (cortisone) to control your allergies or asthma? If so, how many times? _____
m. Have you ever been hospitalized for your asthma?_____
n. How many times in the past 12 months have you been to the ER with asthma?_____
o. How many puffs per week of your quick relief inhaler (albuterol) do you use?_____
p. How many NIGHTS per week do you wake up coughing or requiring your inhaler?_____
q. What makes your symptoms worse? (allergies, cold, heat, stress)_____
r. What makes your symptoms better? (medication, rest, etc.) _____
s. How often does your asthma interfere with normal activity? □ None □minor □some limitation □extremely limited
t. Have you seen a pulmonologist? If so, name: _____

Insect Allergy (Skip if no history of insect allergy)

a. Have you had a severe allergic reaction to a stinging insect? □ Yes □No
b. Did it cause a large local reaction? □ Yes □ No OR hives, itching, or swelling all over the body? □ Yes □ No
c. What treatment did you receive? □ Antihistamine □ Steroid □ Epinephine (EpiPen)

Food allergy (skip if no food allergy)

Please list all foods and the reactions they cause: _____
_____
_____

Eczema (skip if no history of eczema)

a. What part of your body are affected? _____
b. When did it start? □ Infancy □ Childhood □ Adulthood
c. What lotions/creams/moisturizers are you currently using?_____
d. Detergent currently using:_____ Soap currently using _____
e. Have you used a steroid cream? If so, what type and strength? _____
f. Have you ever had skin infections?_____
g. Are there any known triggers which worsen your eczema? _____
h. If patient is a child, how often do they bathe? _____

Hives/Urticaria (skip if no history of hives/urticaria)

a. Where to hives occur?_____
b. What makes hives better?_____
c. How long have you had the hives?_____
d. Any associated symptoms with hives? □ swelling □ dizziness /fainting □ throat swelling □ fever □ nausea □ vomiting □ joint symptoms □ bruising
e. What treatments have you used?_____

Swelling (skip if no history of swelling)

a. Where does swelling occur? □lips □tongue □face □throat □hands/arms □legs/feet
b. Does swelling occur with hives? □Yes □ No
c. Have you had abdominal pain/cramping with hives? □ Yes □ No
d. Is there a family history of swelling? □ Yes □ No
e. Have you ever been hospitalized due to hives/swelling? □ Yes □ No
f. What treatments have you used? _____

Latex allergy: (skip if no history of latex allergy)

a. Have you ever been diagnosed with latex allergy? □Yes □ No
b. What symptoms/reactions have you had? _____

Contact dermatitis: : (skip if no history of contact dermatitis)

a. Have you ever been diagnosed with contact dermatitis? □Yes □ No
b. What symptoms/reactions have you had? _____

Infection history

a. Number of ear infections: _____in the past 12 months _____total in lifetime
b. P.E tubes: □ Yes □ No _____# of sets
c. Number of sinus infections: _____in the past 12 months _____total in lifetime
d. Number of pneumonias: _____in the past 12 months _____total in lifetime
e. Number of antibiotics taken in the past year_____
f. Name of antibiotics taken_____
g. Number of hospitalizations for infections:_____ Type of infections: _____

Previous Allergy Evaluation & Treatment:

a. Name of Allergist and city:
_____
b. Were you tested for allergies by skin prick test or blood test? If so, when:
_____
c. Have you ever received Allergy Shots? If so, when and for how long?
_____

PAST MEDICAL HISTORY:

Medical Problems: (Please circle)

High Blood Pressure	Diabetes	Thyroid Problem	High Cholesterol	Heart Disease
Abnormal Chest x-ray	Sleep Apnea	Glaucoma	Stomach ulcer	Prostate
Heartburn/Reflux	Cancer	HIV/AIDS	Hepatitis	Positive TB test
Depression	Arthritis	Blood Transfusion	Kidney disease	Autoimmune

a. Other medical problems not listed above: _____
b. Please list all surgeries and hospitalizations that you have had:_____
_____
c. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing problem? Comment on results.
_____
_____

d. Are you up to date on all recommended vaccinations? _____ Have you had a flu shot this season? _____

e. If patient is a child (<18 years): Birth weight:_____ □Normal delivery □C-section
Reason for C-section:_____ Pre-term? _____

FAMILY HISTORY:

a. Which of your relatives have **allergies (food, environmental, eczema), asthma, polyps**? (please circle)
Mother/Father/Sister/Brother/Children/Other._____
_____
b. Are there any diseases or disorders that run in your family? (Diabetes, high blood pressure, heart disease, cancer, autoimmune disease, etc.)_____
_____

ALLERGY/IMMUNOLOGY NEW PATIENT QUESTIONNAIRE

SOCIAL HISTORY:

a. Do you currently smoke tobacco? (How much and for how long?) _____
b. Have you ever smoked? (How much and for how long?)_____
c. How much alcohol do you drink?_____
d. Do you use recreational drugs?_____
e. What are your daily activities/hobbies? _____
f. If patient is a child, what grade in school? _____ School/daycare:_____

ENVIRONMENTAL HISTORY:

a. Do you live in an □ apartment □ house □ condo □ mobile home
b. Do you have any animals in the home? (Type and how long?)_____
c. Do you have any wall-to-wall carpeting in your home? _____ In the bedroom?_____
d. Do any smokers live in the home? _____ Smoke: Indoor/outdoor ?
e. What type of pillow do you have? □ Feather □ Cotton □ Other _____
f. What type of mattress/bedding do you have? (circle) Standard/Waterbed/Feather/Other_____
g. Do you use allergy-proof mattress and/or pillow encasings? _____
h. Type of heater: □ Gas/propane heat □ Electric heat □ Space heater □ Wood-burning fireplace
i. Type of air conditioner: □ Central A.C. □ Window A.C.
j. Are there any problems with mold/mildew, mice, or cockroaches in the home? _____
k. Do you have regular exposure to farm animals (horses, cows) OR other furry animals (hamster, rabbit, etc.) _____
l. What is your occupation? _____ If retired, previous work:_____
m. Are you exposed to any toxic chemicals, noxious substances at work? _____

REVIEW OF SYSTEMS: (Do you have any of the following symptoms? Please check all that apply)

General □Weight loss □Fevers □Change in appetite □Night sweats	**Eyes** □Double vision □Blurry vision □Itching □Red	**Pulmonary** □Cough □Wheezing □Trouble breathing	**Neurological** □Weakness □Headaches □Numbness	**Musculoskeletal** □Joint aches □Joint swelling □Muscle aches □Stiffness	**Endocrine** □Cold/heat intolerance □Increased thirst □Frequent urination
Head/Neck □Swelling □Pain □Sinus pressure □Post nasal drip	**Ears/Nose/Throat** □Trouble hearing □Ringing in ears □Congestion □Nose bleeds □ Voice changes	**Cardiovascular** □Chest pain □Ankle swelling □Palpitation □Chest tightness	**Gastrointestinal** □Nausea/vomiting □Diarrhea □Heartburn □Trouble swallowing □Constipation	**Genitourinary** □Pain with urination □Blood in urine □Urinary urgency □Urinary frequency	**Skin** □Rashes □Skin infections □Skin lesions

Patient/Parent signature_____
Date_____

Reviewed by Provider_____
Date_____