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NEW PATIENT QUESTIONNAIRE: ADULTS

INSTRUCTIONS: Carefully complete all 3 pages of this form in full. Relate all answers to your own experience.

NAME: _____ AGE: _____ DOB: _____ DATE: _____

Referred by: _____ Your primary physician is: _____
Address (if not local): _____

Circle the allergy problem(s) that you have:

Runny / stuffy nose (hay fever)	Sinusitis	Insect allergy	Eye or ear problems
Asthma	Eczema / rash	Drug allergy	Headache
Cough	Hives or swelling	Food allergy	Frequent infections

The major problem you wish to discuss is: _____

List *all* prescription and over-the-counter medications you are now using (name & dosage): _____

_____

_____

_____

List medications you have tried in the past for your allergy problems: _____

_____

Are you allergic to any medicines? List drug, type of reaction and year: _____

_____

I. Symptoms

Eyes: Itch___ Swell___ Burn___ Tear___ Discharge___ Dry___

Ears: Itch___ Fullness___ Popping___ ⇓ hearing___ Pain___ Ringing___

Nose: Sneeze___ Itch___ Runs___ Stuffy___ Mouth breather___
Snoring___ Yellow/green drainage___ Decreased smell___ Decreased taste___
Headache___: what part of head_____ how often_____ how severe_____

Throat: Itch___ Sore___ Post nasal drip___ Throat clearing___ Swelling___

Chest: Cough___ Phlegm___ Hoarseness___ Asthma diagnosed by a physician___
Wheezing___ Chest tightness___ Shortness of breath with exercise___ Heartburn___

Skin: Eczema___ Hives___ Swelling___ Rashes___ Where on body?_____

A. *Respiratory allergies*

1. Age of onset of your hay fever _____, and/or asthma _____.
2. Do you have daily symptoms? _____
3. What time of year are your allergies or asthma worse? (please list months) _____
4. What time of day or night is the worst for your symptoms? _____
5. Does any particular exposure (e.g. cat, smoke, weather change, work, school) make you worse?(list) _____

   _____
6. Do you get sinus infections (yellow/green nasal drainage, pain, etc.)? _____ How often? _____

   How is it usually treated? _____

7. Have you had nose or sinus surgery? _____

8. Have you been told by a physician that you have nasal polyps?_____

9. Have you ever been hospitalized for your asthma? _____ Emergency room? _____

B. *Insect allergy*

Have you had a severe allergic reaction to a stinging insect (bee, wasp, yellow jacket, hornet, fire ant)? _____(explain)

_____

C. *Food allergies*

Please list all foods and reaction they cause: _____

_____

D. Have you had ***hives*** (welps) before? (when and for how long)_____

E. Have you had ***eczema*** (red, scaly, itchy skin) previously? _____

F. Are you sensitive to ***latex*** or ***rubber*** products? (explain) _____

II. Previous Allergy Evaluation and Treatment

A. Name of allergist and city _____

B. Were you tested for allergies by skin test or blood test? _____ When _____ Results: _____

_____

C. Have you received allergy shots? _____ When, how long: _____

D. Have you ever had steroid pills (dosepak, Prednisone) or shots (cortisone)? _____ When _____

III. Past Medical History

A. Medical problems: (please circle)

Diabetes	Thyroid problem	High cholesterol	Heart disease
High blood pressure	Prostate	Glaucoma	Stomach ulcer	Hiatal hernia
Abnormal chest x-ray	Depression	Positive Tb test	Arthritis	Hepatitis
GERD (acid reflux)	Cancer	HIV / AIDS	Other: _____	

B. Please list all important operations and other hospitalizations that you have had: _____

_____

C. Have you ever had a blood transfusion? _____

D. Have you had a chest x-ray, sinus x-ray, breathing test, blood tests? Comment on results. _____

_____

E. When was your last tetanus vaccination? (every 10 years) _____

F. Do you receive the flu vaccine yearly? _____

G. Have you received the Pneumovax? (pneumonia vaccine) _____

IV. Family History

A. How many siblings do you have? ____ brothers, _____ sisters. How many children? _____ boys, _____ girls

B. Do these people or your parents have any of the allergy problems mentioned above? (list and comment) _____

_____

C. Are there any hereditary diseases or other disorders that seem to occur frequently in your family? _____

_____

V. Personal and Environmental History

A. Do you presently smoke? (how much and how long) _____

B. Have you ever smoked? (how much and how long) _____ Quit: ____ years ago

C. Are there smokers other than yourself at home? _____, how many _____

D. Do you have animals at home? (type and for how long) _____

E. Do you have mostly wall-to-wall carpeting in your home? _____ In your bedroom? _____

F. What is your occupation? _____

- Are you exposed to any toxic chemicals, noxious substances at work? _____

- Has your problem caused you to miss work? _____

G. How much alcohol do you drink? _____

H. Do you use recreational drugs? (<u>this is confidential</u>) _____

I. How long have you lived in the area? _____ If not here year round, other home is in _____

J. How many other people live in your home? _____ Are you: married / single / separated / divorced / widow

K. Do you have a standard mattress? _____ or waterbed? _____

L. Do your symptoms become better or worse on vacations or at the beach? _____

M. What are your daily activities, hobbies? _____

VII. Review of Systems

Do you have any of the following? (check)

<u>General</u>
____ weight loss
____ fevers
____ night sweats
____ loss of appetite
____ dry mouth
____ snoring

<u>Eyes and ears</u>
____ dry eyes
____ change in vision
____ trouble hearing
____ ringing in ears

<u>Skin</u>
____ skin rashes

<u>Endocrine</u>
____ cold / heat intolerance
____ increased thirst
____ frequent urination

<u>Gastrointestinal</u>
____ nausea / vomiting
____ diarrhea
____ change in bowel habits
____ trouble swallowing
____ heartburn

<u>Cardiovascular</u>
____ chest pain
____ chest pain with exercise
____ calf pain with exercise
____ ankle swelling

<u>Neurological</u>
____ weakness / clumsiness
____ tingling/numbness of extremities

<u>Psychological</u>
____ fearful, anxious
____ excessive worry
____ trouble sleeping

<u>Kidney</u>
____ trouble starting urine
____ loss of urine with cough / sneeze
____ frequent nighttime urination

<u>Blood</u>
____ anemia (low blood)
____ bleed or bruise easily
____ swollen lymph nodes

<u>Musculoskeletal</u>
____ morning joint stiffness and aching
____ painful, swollen joints
____ muscle tenderness or pain
____ muscle weakness
____ abnormal bone density

<u>Gynecological</u>
____ excess bleeding
____ changes in menstrual cycle
____ post-menopausal

VIII. Additional Information

Anything else you want to discuss during your initial visit? _____

_____

_____

_____

_____