Dayton Arthritis and Allergy Center

Allergy/Immunology New Patient Questionnaire

Your answers on this form will help your doctor get an accurate history of your medical concerns and conditions in order to better help you. Please bring this completed form to your first appointment

Patient name: ____ Date:______________________

Who referred you to our clinic? ___________________________ PCP: ______________________

Please describe the reasons for your allergy visit and what you hope to accomplish:

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1. **Have you ever had any of the following problems?** Please fill in circle completely

Yes	No	Problems	Age of Onset	Comments
○	○	Nasal allergies (Runny, stuffy, itchy nose, sneezing)		
○	○	Sinus problems		
○	○	Asthma (Wheezing)		
○	○	Any other breathing problems		
○	○	Eczema or other rashes		
○	○	Latex allergy		
○	○	Vaccine allergy		
○	○	Stinging insect allergy		
○	○	Frequent infections		

2. **Have you ever had the following symptoms? If not, leave blank.** Please fill in circle completely.

	Mild	Moderate	Severe	What time of year are they the worst?
Sneezing	○	○	○	
Itchy nose	○	○	○	
Runny nose	○	○	○	
Dripping sensation at the back of the throat	○	○	○	
Throat clearing	○	○	○	
Nasal congestion	○	○	○	
Ear pain/popping/fullness	○	○	○	

	Mild	Moderate	Severe	What time of year are they the worst?
Red eyes	○	○	○	
Itchy eyes	○	○	○	
Watery eyes	○	○	○	
Headaches	○	○	○	
Sinus pain or pressure	○	○	○	
Discolored nasal drainage	○	○	○	
Decreased sense of smell	○	○	○	
Snoring	○	○	○	
Mouth breathing	○	○	○	
Nighttime pauses in breathing	○	○	○	
Waking up at night choking or gasping for air	○	○	○	

3. **If you have asthma, have you ever been:** Please fill in circle completely.

	Yes	No	
Hospitalized for asthma?	○	○	When?
Treated in the emergency room for asthma?	○	○	When?
Treated with oral steroids for an asthma attack?	○	○	How many times?
How many asthma attacks do you estimate you have had in your lifetime?			
How many asthma attacks in the past year?			

4. **Over the last four weeks, have you had problems with:** Please fill in circle completely.

	Never	1-2 times a week	3-6 times a week	Once a day	More than once a day
Cough	○	○	○	○	○
Wheeze	○	○	○	○	○
Chest tightness	○	○	○	○	○
Shortness of breath	○	○	○	○	○
Use of rescue inhaler (e.g. Albuterol)	○	○	○	○	○

Have you had problems with waking up at night because of trouble breathing? Please fill in circle completely

Not at all	1-2 times per month	3-4 times per month	More than once a week	Every night
○	○	○	○	○

5. Please check any factors that seem to trigger your allergy or asthma symptoms. Please fill in circle completely.

	Yes	No		Yes	No		Yes	No
Pollens	○	○	Cold air	○	○	Strong odors	○	○
Raking leaves	○	○	Infections	○	○	Stress	○	○
Dust	○	○	Smoke	○	○	Menstruation	○	○
Mold/Mildew	○	○	Air conditioning	○	○	Alcohol	○	○
Exercise	○	○	Forced air heat	○	○	Dried fruits	○	○
Animals (specify)	○	○	Exposures at work (specify)	○	○	Medications (specify)	○	○

6. **Have you missed time from school or work because of your allergies or asthma?** __________

If so, how many days in the past year? __________

7. **Have you ever had allergy testing?** __________ **If yes, date(s):** __________

Physician's name: ______________________________

Results of these tests (if possible, please provide us with a copy): ______________________________

8. **Please list below any medications you have tried for your allergies or asthma**

Medication	Dose	Frequency	How long did you try it?	Effectiveness			Side effects
				Helped a little bit	Helped a moderate amount	Completely relieved symptoms	

9. **Have you ever received allergy injections?** __________ If yes, date(s): ____________________

Were they of any benefit? __________

10. Have you had any reactions to foods? If so, please describe the most severe reaction below:

Food	Age of onset	Symptoms	Date food last eaten

11. MEDICATION ALLERGIES. List any medication allergies and the type of reaction that occurred.

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12. **SOCIAL AND ENVIRONMENTAL HISTORY.** Please fill in circle completely

Have you ever smoked?	Current ○	Previous ○	Never ○	Packs per day?	How many years?
Does anyone else at your home smoke?	Yes ○	No ○	If yes, where?	Indoors ○	Outdoors ○
Do you live in a:	House ○	Trailer ○	Apartment ○	Age of building?	
Any rooms that are damp or musty	Yes ○	No ○	Has the house ever been flooded?	Yes ○	No ○
Carpet in the bedroom	Yes ○	No ○	Fan in the bedroom?	Yes ○	No ○
Dust mite covers on mattress or pillows?	Yes ○	No ○	Feather pillows or comforters?	Yes ○	No ○
Pets?	Yes ○	No ○	Type? (cat, dog, bird, etc)	Indoors ○	Outdoors ○
Occupation? Any work exposures?					

13. FAMILY HISTORY. Do any members of your biologically related family have a history of the following?
Please fill in circle completely

	Yes	No	If yes, list all relatives (e.g. parents, brothers, sisters, children, aunts, uncles, grandparents, etc.)
Asthma	○	○	
Allergic rhinitis ("hay fever", nasal allergies)	○	○	
Atopic dermatitis or Eczema	○	○	
Food allergies	○	○	
Hives	○	○	
Frequent infections	○	○	

14. REVIEW OF SYSTEMS. Please completely fill in the circle below regarding any symptoms you are currently experiencing.

	Yes	No		Yes	No		Yes	No
Eyes			**Cardiovascular**			**Neurologic**		
Pain	○	○	Racing heart	○	○	Dizziness	○	○
Swelling	○	○	Chest pain	○	○	Headaches	○	○
Blurry Vision	○	○	**Gastrointestinal**			**Psychiatric**		
Double vision	○	○	Heartburn	○	○	Feeling anxious	○	○
Dry eyes	○	○	Stomach pain	○	○	Irritability	○	○
Ears			Nausea	○	○	Difficulty concentrating	○	○
Pain	○	○	Vomiting	○	○	**Constitutional**		
Ringing	○	○	Trouble swallowing	○	○	Fevers	○	○
Hearing loss	○	○	**Musculoskeletal**			Weight loss	○	○
Respiratory			Joint pain	○	○	**Skin/Hair**		
Shortness of breath	○	○	Joint swelling	○	○	Dry skin or hair	○	○
Cough	○	○	Muscle aches	○	○	Itching	○	○
						Rash	○	○

15. Current medications. Please list current medication, dose, and how often this is taken. Please use separate sheet of paper, if necessary.

Medication name	Dose	Frequency

16. Medical history. Please list any medical conditions.

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17. Surgical History/Hospitalizations. Please list any previous surgeries or hospitalizations.

Surgery/Hospitalization	Date