

Allergy and Asthma New Patient Form

Name:		Date of Birth:		Date:
Patient Questionnaire				
Have you experienced any Nasal/Sinus symptoms? (Circle one)		Yes	No	
(if yes, please answer questions below; if no, skip and go to the Eye Symptoms section)				
When did the symptoms start? What was your age or the year?		Age:	Year:	
Intensity (Circle all that apply)	Mild	Moderate	Severe	
Symptoms (Circle all that apply)	Runny nose Stuffy nose Sneezing Throat clearing	Itchy mouth Itchy throat Itchy nose Itchy ears	Headache Sinus pressure/pain PND Cough	Nosebleeds: circle Drops of blood ? Or Gushing blood? How frequent?
Timing: (Choose one of the following three options):	Year-round	Seasonal: (please circle all problem seasons): Spring Summer Fall Winter	Year-round with seasonal worsening (which seasons worse, please circle): Spring Summer Fall Winter	
Medication taken: (Circle all that apply and whether it was helpful or not):	Fexofenadine (Allegra): helpful, or not helpful		Benadryl: helpful, or not helpful	
	Loratadine (Claritin): helpful, or not helpful		Flonase/fluticasone: helpful or not helpful	
	Cetirizine (Zyrtec): helpful, or not helpful		Afrin: helpful, or not helpful	
	Levocetirizine (Xyzal): helpful, or not helpful		Other: helpful, or not helpful	
Past allergy testing? (Circle one of the following): Yes or No	If Yes: When was the test performed? Age or year: _____	If Yes, what were the results (Circle all that apply): Pets Pollen Dust Cockroach Mold	Allergy shots received? (Circle one): Yes or No	
			If yes, how long on shots? _____ Were they helpful? (Circle one): Yes or No	
Infections: (Circle all that apply):	Sinusitis: how many per year? _____ Are antibiotics given every time? (Circle one): Yes or No		Bronchitis: how many per year? _____ Are antibiotics given every time? (Circle one): Yes or No	
	Pneumonia: how many per year? _____ Are antibiotics given every time? (Circle one): Yes or No			



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EYE SYMPTOMS: (Circle one)		Yes	No		
(if yes, please answer questions below; if no, go to the Breathing Symptoms section)					
When did the symptoms start? What was your age or the year?		Age:		Year:	
Symptoms (Circle all that apply)	Itchy	Puffy	Particular triggers: (Circle all that apply) Pollen Pets Unknown Other: _____	Eye drops used: (Circle one): Yes or No If yes, name of the drops? _____	
	Watery	Red		Was it helpful? (Circle one): Yes or No	
BREATHING SYMPTOMS: (Circle one)		Yes	No		
(if yes, please answer questions below; if no, go to the GERD section)					
When did the symptoms start? What was your age or the year?		Age:		Year:	
Symptoms (Circle all that apply)	Cough	Shortness of Breath	Chest tightness:	Wheezing	
	In the past month, symptoms more than twice a week? (Circle one): Yes or No		In the past month, night symptoms more than twice a month? (Circle one): Yes or No		
Triggers (Circle all that apply)	Cold air	Exercise	Smoke	Emotions: such as Sadness, Anxiety Excitement	
	Humid air	Certain Pets	Certain Seasons		
	Infection	Strong Odors	Taking Aspirin		
Hospitalizations for asthma (Circle one):	Yes	No			
Medications taken:	Yes	No	If yes, was the medication helpful? (Circle one): Yes or No		
Current medications:					
Were you seen by a lung doctor (Pulmonologist)	Yes	No	If yes, when was your last visit? _____		
GERD: (Circle one)		Yes	No		
(if yes, please answer questions below; if no, go to the Hives/Swelling section)					
When did the symptoms start? What was your age or the year?		Age:		Year:	
What are your Triggers					
Medications taken:	Yes	No	If yes, was the medication helpful? (Circle one): Yes or No		
Current medications:					

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HIVES / SWELLING: (Circle one)		Yes	No				
(if yes, please answer questions below; if no, go to the Eczema section)							
When did the symptoms start? What was your age or the year?			Age:	Year:			
Hives: located on your body							
How often do you breakout? (Circle one)	Daily	Most days of the week	Less than 2 days a week	Once or twice a month	Less than once a month		
How long do the hives last once they start? (Circle one)	Hours	Days	Are they itchy? Yes or No				
Is there any swelling? (Circle one)	Yes	No	If Yes, what location on your body (circle all that apply) Face, arms, chest, back, buttocks, legs, other: _____				
How often is there swelling: (Circle one)	Daily			Once or twice a month			
	Most days a week			Less than once a month			
	Less than 2 days a week						
How long do the hives last once they start? (Circle one)	Hours	Days					
What are your Triggers? (Circle all that apply)	Certain food(s)		Certain Med(s)	Insect Stings	Latex	Heat	Cold
	Taking Aspirin		Pressure on skin	Contact with Pet		Infection	Stress
Medications taken:	Yes		No	If yes, was the medication helpful? (Circle one): Yes or No			
Current medications:							
Autoimmune disease in you or your blood-related family?	Yes	No	If Yes, (Circle all that apply)	Lupus	Rheumatoid Arthritis	Ulcerative Colitis	
				Thyroid Disease	Chron's Disease	Multiple Sclerosis	
ECZEMA: (Circle one)		Yes	No				
(if yes, please answer questions below; if no, go to the Food Reaction section)							
When did the symptoms start? What was your age or the year?			Age:	Year:			
What are the affected area(s) located on your body?							
What moisturizers do you use?	Was it helpful? Yes or No		How itchy? (Circle all that apply)	Mild	Moderate	Severe	
How itchy? (Circle all that apply)	Mild		Moderate	Severe			
Medications taken:	Yes		No	If yes, was the medication helpful? (Circle one): Yes or No			
Were Biologic/ Shots used?	Yes		No	Helpful? Yes or No			

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FOOD REACTIONS: (Circle one)				Yes	No						
(if yes, please answer questions below; if no, go to the Med/Drug Reaction section)											
What food caused the reaction?											
When did the symptoms start? What was your age or the year?				Age:		Year:					
What Symptoms? (Circle all that apply)	Itch		Lip Swelling		Throat Swelling		Cough		Chest Tightness	Dizziness	Nausea/Vomiting
	Hives		Tongue Swelling		Shortness of Breath		Wheezing		Light-Headedness	Stomach Discomfort	Diarrhea
How quickly did the reaction occur after eating food?											
How many bites were eaten before the reaction? _____											
Were medications taken to stop the reaction?				Yes	No	Were they helpful?				Yes	No
Did you go to Urgent Care, ED, or your Primary Care office?				Yes	No	Did you get an Epinephrine auto-injector?				Yes	No
Have you eaten the food again? If yes, please answer below				Yes	No	If yes, did you have the same reaction?				Yes	No
MEDICATION/DRUG REACTION: (Circle one)				Yes	No						
(if yes, please answer questions below; if no, go to the Sting/Bite Reaction section)											
What medication causes a reaction?											
When did this happen? What was your age or the year?				Age:		Year:					
What Symptoms? (Circle all that apply)	Itch		Lip Swelling		Throat Swelling		Cough		Chest Tightness	Dizziness	Nausea/Vomiting
	Hives		Tongue Swelling		Shortness of Breath		Wheezing		Light-Headedness	Stomach Discomfort	Diarrhea
How quickly did the reaction occur after taking the medication? _____											
Medications taken to stop the reaction?				Yes	No	Were they helpful?				Yes	No
Did you go to Urgent Care, ED, or your Primary Care office?				Yes	No	Did you get an Epinephrine auto-injector?				Yes	No
Have you taken the medication again?				Yes	No	If yes, did you have the same reaction?				Yes	No
STING/BITE REACTION: (Circle one)				Yes	No						
(if yes, please answer questions below; if no, go to the Sting/Bite Reaction section)											
When did this happen? What was your age or the year?				Age:		Year:					
Insect?				Yes	No	What insect?					
What Symptoms? (Circle all that apply)	Itch		Lip Swelling		Throat Swelling		Cough		Chest Tightness	Dizziness	Nausea/Vomiting
	Hives		Tongue Swelling		Shortness of Breath		Wheezing		Light-Headedness	Stomach Discomfort	Diarrhea
How quickly did the reaction occur after the sting? _____											
Medications taken to stop the reaction?				Yes	No	Were they helpful?				Yes	No
Did you go to Urgent Care, ED, or your Primary Care office?				Yes	No	Did you get an Epinephrine auto-injector?				Yes	No
Have you gotten stung again?				Yes	No	If yes, did you have the same reaction?				Yes	No
ANY OTHER CONCERNS?											