NEW PATIENT QUESTIONNAIRE

Name:_________________________________ Age:______ DOB:__________ Date:________________

Reason you're being seen?____________________ When did your symptoms first begin? ________________
When, if so, did they get worse?______________________

Are your symptoms: ☐seasonal * * ☐all year long ☐ all year long, with seasonal worsening * *
* * Circle the worst months: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

What makes your symptoms worse:

Irritants	Weather	Medicine	Allergens	Location	Other
☐ smoke ☐ air pollution fumes or car exhaust ☐strong odors or perfumes	☐ cold air ☐ rapid temperature change (e.g. going from cold outdoors to indoor heat)	☐ aspirin ☐ Non-steroidal anti-inflammatory agents (e.g. Motrin, Advil, Aleve)	☐ grass/tree/weeds ☐dust or vacuuming ☐ damp/musty area ☐animals __dog __cat __other	☐ outdoors ☐ indoors ☐ daycare ☐ home ☐ school ☐ work	___________ ___________ ___________ ___________ ___________ ___________ ___________

Social History

Occupation/Job/School :___________________________

Smoking status:
☐ Current smoker # of yrs ______ Packs per day_______

Second hand smoke exposure: ☐ Yes ☐ No

Pets in the home: (circle) Dog Cat Rabbit Hamster Guinea Pig Other__________________

Housing: ☐ House ☐ Apartment ☐ Urban ☐ Suburb ☐ Farm/Rural # of year at this residence______

Heating: ☐ Gas ☐Electric ☐ Wood Burning ☐ Oil **A/C:** ☐ Central A/C ☐ Window A/C ☐ None
Humidifier: ☐ Room ☐ Central ☐ None

Bedding: Pillow: ☐ Feather/Down ☐ Synthetic **Comforter:** ☐ Feather/Down ☐ Synthetic

Flooring: Bedroom: ☐ Carpet ☐ Tile ☐ Wood **House:** ☐ Carpet ☐ Tile ☐ Wood

Hobbies/Sports:____

Check any of the illnesses/medical conditions that you have had.

☐ Asthma
☐ COPD
☐ High blood pressure
☐ Hay fever
☐ Pneumonia
☐ Anxiety
☐ Heart attack/angina
☐ Atopic Dermatitis/eczema
☐ Headaches
☐ Arthritis
☐ Osteoporosis
☐ Diabetes
☐ Irritable bowel
☐ Thyroid disease
☐ Heartburn/acid reflux
☐ Psoriasis

(over)

List all surgeries/operations/hospitalizations: ____

____

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

1)______________________ **4)**______________________ **7)**______________________

2)______________________ **5)**______________________ **8)**______________________

3)______________________ **6)**______________________ **9)**______________________

What medications have you tried for your allergy problems in the past? Has it been effective? ______________

____

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

____

Allergy Review of Symptoms - Check all that apply or are abnormal:

Headaches: ☐ Frontal ☐ Maxilla ☐ Temporal **Sinusitis:** Location___________ ☐ **Snoring** ☐ **Sleep Apnea**

Eyes: ☐ Redness ☐ Itch ☐ Tearing ☐ Puffiness

Ears: ☐ Freq-Infect ☐ Hearing Loss ☐ Pain ☐ Tubes (age)___ ☐ Pressure/congestion

Nose: ☐ Colds ☐ Itch ☐ Runny nose ☐ Bleeding ☐ Stuffiness ☐ Sneezing ☐ Post Nasal Drip ☐ Decreased Sense of Smell/Taste

Throat: ☐ Freq-Infect ☐ Clearing Freq ☐ Bad Breath ☐ Voice Change ☐ Sore Throat ☐ Hoarseness ☐ Swollen Glands ☐ Tonsils or Adenoids removed (age)______

Chest: ☐ Asthma ☐ Chronic Cough ☐ Bronchitis/Pneumonia ☐ Shortness of Breath ☐ Chest Tightness ☐ Wheezing

Skin: ☐ Eczema ☐ Urticaria (hives) ☐ Insect bites ☐ Contact Dermatitis ☐ Atopic Dermatitis (eczema) ☐ Angioedema (swelling)

GI: ☐ Nausea/Vomiting ☐ Bowel Change ☐ Appetite Change ☐ Lactose Intolerance ☐ Jaundice

GU: ☐ Infection ☐ Blood in Urine ☐ Incontinence ☐ Burning Urination

General: ☐ Weight loss ☐ Emotional Problems ☐ Sleep Pattern ☐ Missed School/Work ☐ Muscle Aches ☐ Night Sweats

Number of Courses of Antibiotics in Past 12 Months: ____________

Do you know of any blood relatives who have or had the following? Please check and give relationship.

☐ Asthma ______________________________

☐ Allergic Rhinitis/Hay Fever______________________________

☐ Food Allergies______________________________

☐ Atopic Dermatitis/Eczema______________________________

☐ Thyroid Disease______________________________

☐ Angioedema (Hereditary Angioedema)______________________________

☐ Hives (Urticaria)______________________________

______________________ Physician

______________ Date