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NEW PATIENT QUESTIONNAIRE

Please answer all of the questions that apply to you or your child (hearafter referred to as "you") and bring this from with you on the day of your visit.

PATIENT'S NAME:	DATE OF BIRTH:
REFERRED TO THIS OFFICE BY:	PRIMARY CARE PHYSICIAN: ADDRESS: PHONE:

1. **CHIEF COMPLAINT** *(Reason for Visit):* _____

2. **HISTORY OF PRESENT ILLNESS (PHYSICIAN TO COMPLETE)**: _____

3. **REIVEW OF SYSTEMS (PROBLEMS):** *Have you had any of the following symptoms or conditions? Check all that apply.*

System	***No***	***Yes***	***Check all that apply***	***Age of onset***	***All-year or seasonal?***	***Indoor or outdoor?***	***Comments***
Eyes	☐	☐	☐ red ☐ watery ☐ itchy ☐ swollen ☐ mucus discharge ☐ light hurts eyes				
Ears	☐	☐	☐ itchy ☐ frequent infections (#__/yr)				
Nose	☐	☐	☐ stuffy ☐ itchy ☐ sneezing ☐ runny, ____ color ☐ snoring ☐ mouth breathing				
Sinus	☐	☐	☐ frequent sinus infections (#_____) ☐ thick discharge, yellow/green ☐ headaches				
Throat	☐	☐	☐ post nasal drip ☐ sore ☐ itchiness ☐ throat clearing ☐ difficulty swallowing				
Chest	☐	☐	☐ cough ☐ wheezing ☐ shortness of breath ☐ bronchitis ☐ pneumonias				

System	*No*	*Yes*	*Check all that apply*	*Age of onset*	*All-year or seasonal?*	*Indoor or outdoor?*	*Comments*
Abd/GI	☐	☐	☐ frequent diarrhea ☐ vomiting ☐ reflux ☐ food allergies				
Skin	☐	☐	☐ eczema ☐ hives ☐ dry skin ☐ dry patches ☐ frequent infections				
General	☐	☐	☐ weight loss ☐ failure to gain weight				
Other	☐	☐	☐ other infections requiring antibiotic therapy				

4. **DIETARY HISTORY/FOOD REACTIONS:**

- *If patient is a child, is or was the patient exclusively breastfeed?* _____
  for how long? _____
- *When was formula introduced?* _____
  Which formula? _____
  Reactions? _____
- *Do you have any special diet?* _____
- *Are you avoiding any foods?* _____

FOOD	AGE	SYMPTOMS/REACTIONS	STILL AVOIDING?

5. **PRECIPITATING FACTORS/TRIGGERS:** *Please check boxes*

	Yes	No		Yes	No
Tree Exposure	☐	☐	Tobacco smoke	☐	☐
Grass Exposure	☐	☐	Exercise	☐	☐
Raking leaves/mowing lawns	☐	☐	Animals (cats, dogs, etc.)	☐	☐
Damp areas with mold and mildew	☐	☐	Cold or hot water	☐	☐
Sweeping, dusting, vacuuming	☐	☐	Colds (upper respiratory infections)	☐	☐
Smog/air pollution	☐	☐	Cleaning agents, fumes, perfumes	☐	☐
Aspirin/Ibuprofen/other drugs	☐	☐	Menstrual periods	☐	☐
Nighttime	☐	☐	Insect stings	☐	☐
Temperature changes (hot/cold)	☐	☐	Others:	☐	☐
Itchy lips/throat after eating bananas, melons, peaches, apples, kiwi, pears, citrus shellfish, peanuts, or tree nuts	☐	☐		☐	☐

6. **PREVIOUS ALLERGY EVALUATIONS AND TREATMENT:**

- *Have you ever had allergy skin testing?* ☐ *Yes* ☐ *No* *Date:* _____ *Physician:* _____
  Results? _____
- *Have you ever had **RAST** testing (blood test)?* ☐ *Yes* ☐ *No* *Date:* _____ *Physician:* _____
  Results? _____
- *Have you ever received immunotherapy (allergy shots)?* ☐ *Yes* ☐ *No*
  Date: _____ *Physician:* _____

- *Have you ever used:*

☐ **Nasal Sprays:** ☐ Rhinacort ☐ Flonase ☐ Nasonex ☐ Veramyst ☐ Qnasl ☐ Zetonna ☐ Patanase ☐ Dymista ☐ Others _____

☐ **Inhalers:** ☐ Proventil/albuterol ☐ Flovent ☐ Pulmicort ☐ Advair ☐ Qvar ☐ Dulera ☐ Asmanex ☐ Symbicort ☐ Others _____

☐ **Medications:** ☐ Singulair ☐ Claritin ☐ Allegra ☐ Bendadryl ☐ Atarax ☐ Prednisone ☐ Prelone ☐ Zyrtex ☐ Xyzal ☐ Others _____

7. **PAST MEDICAL/SURGICAL HISTORY:** *Have you ever had any of the following conditions?*

List other medical illnesses:	**ER/Hospitalizations?** When/why	**Any surgeries?**
☐ Cough up blood	**Abnormal tests?**	☐ Tonsils/adenoids removed, if yes, when? _____
☐ Tuberculosis	☐ Chest XR, when _____	☐ Sinus surgery?
☐ Glaucoma	☐ CT scan	☐ Myringotomy (tubes in ears)?
☐ Kidney problems		
☐ Snoring/mouth breathing		
☐ Diabetes		

8. **MEDICATIONS:** *Do you take any medications currently? Please list all medications and dosages.*

_____

_____

_____

_____

9. **ALLERGIES:** *Do you have any known allergies to medications? If so, what was your reaction?*

_____

_____

_____

10. **FAMILY HISTORY:**

Mother's health _____ age _____ Father's health _____ age _____

Brother(s) health _____ age _____ Sister(s) health _____ age _____

Do any family members have a history of allergic or immunologic conditions? If yes, please complete all that applies.

ALLERGIES/DISEASE	Yes	No	LIST RELATIVES (INDICATE IF OUTGROWN AND WHEN)
Asthma	☐	☐	
Frequent bronchitis	☐	☐	
Frequent pneumonias	☐	☐	
Cystic Fibrosis or other lung disease	☐	☐	
Environmental allergies (nose and eyes)	☐	☐	
Chronic sinus problems	☐	☐	
Hives/urticaria	☐	☐	
Eczema	☐	☐	
Insect allergy	☐	☐	
Drug allergy	☐	☐	
Food allergy	☐	☐	
Immune disorder	☐	☐	
Autoimmune disorder (lupus, thyroid disease, rheumatoid arthritis)	☐	☐	
Early unexplained death in infancy	☐	☐	
Other	☐	☐	

11. **ENVIRONMENTAL/HOME SURVEY:** *List city and states where you have lived, with most recent first.*

	City	State	Years	Effects on symptoms, better/worse/no change
1.				
2.				
3.				
4.				

- Approximately how old is your home? _____
- How long have you lived there? _____
- Is your home a ☐ single family home, ☐ brownstone/townhouse, ☐ apartment?
- Does it have ☐ central air conditioning, ☐ central or forced hot air, ☐ radiator heat, ☐ baseboard, ☐ window air conditioning, ☐ humidifier, ☐ damp areas, ☐ basement, ☐ visible mold, ☐ cockroaches, ☐ smokers?
- Does your bedroom have ☐ wall-to-wall carpeting, ☐ hardwood flooring, ☐ area rugs, ☐ down pillows and/or comforter, ☐ stuffed toys?
- Does your bedroom have ☐ dust mite proof pillow and/or mattress covers, ☐ HEPA filter, ☐ weekly washing of bed linens?
- Please list all fur-bearing pets (cats, dogs, birds, gerbils, hamsters, etc.)

  _____
- Do the pets enter your bedroom? _____ bed? _____
- Is there any location where your symptons are worse? _____
- What is your occupation or parent's occupation if child? _____
  Are your symptoms worse at work? _____
- How many days from school or work have you missed because of your asthma or alleriges? _____
- Smoke exposure: ☐ *Yes* ☐ *No* Where? _____

12. **IMMUNIZATIONS:** (for immune deficiency evaluation patients only)
Please list vaccinations which you have received within the last 5 years.

_____

_____

_____