Allergy Clinic Patient Questionnaire- NEW

Welcome to the Allergy Clinic. Please answer the following questions so we may better assist you.

Name : _____ Date of birth: _____

Contact Number(s):_____

What is your preferred language (written or spoken)?_____
What is your preferred method for learning _____ Verbal _____ Visual _____ Other: _____
Do you have a learning disability, language barrier, hearing/vision deficit? _____ No _____ Yes; if so what? _____
How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? _____ Never _____ Rarely _____ Often _____ Always

Occupation: _____

Hobbies: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION:

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY- INCLUDE YR	FAMILY HISTORY- INCLUDE WHAT RELATIVE(S)
Y N ☐ ☐ Asthma ☐ ☐ Allergies ☐ ☐ Eczema ☐ ☐ Food Allergy ☐ ☐ Insect Allergy ☐ ☐ Chronic/ Recurrent Hives/swelling ☐ ☐ Autoimmune Disease ☐ ☐ Immune deficiency ☐ ☐ Heart Condition Other: ** Additional details regarding allergic conditions will be asked on the back side**	Y N ☐ ☐ Sinus Surgery ☐ ☐ Tonsil or Adenoidectomy Other:	Y N ☐ ☐ Asthma ☐ ☐ Allergies ☐ ☐ Eczema ☐ ☐ Food Allergy ☐ ☐ Latex Allergy ☐ ☐ Insect Allergy ☐ ☐ Chronic/ Recurrent Hives/swelling ☐ ☐ Autoimmune Disease ☐ ☐ Immune deficiency Other:

MEDICATION ALLERGIES: ____ Yes _____No If yes, which medication/reaction? _____

ALLERGY TO LATEX: ____ Yes _____No If yes, what reaction? _____

Tobacco Use? ___ No ___Yes—How Long/How Much?_____ **Alcohol Use?** ____ No _____Yes—How Much?_____

PLEASE LIST OR CIRCLE ALL OF YOUR <u>CURRENT</u> MEDICATION (INCLUDING OVER THE COUNTER):

Allergy medication: Zyrtec Claritin Allegra Benadryl Atarax Singulair Patanol/Pataday
Flonase Nasonex Astelin Nasal saline Afrin Nasal Atrovent Epi-Pen Other: _____

Respiratory Medications: Albuterol inhaler/nebulizer Flovent Advair Symbicort Spiriva Asmanex Other: _____

All other medication not listed above: _____

_____

PLEASE SEE REVERSE SIDE FOR ALLERGY SPECIFIC SCREENING QUESTIONS

BREATHING CONCERNS ____ YES _____NO
Circle all respiratory diagnoses you have: Asthma COPD Reactive airway Disease (RAD) Bronchitis
Symptoms: Cough Wheeze Shortness of breath Chest tightness Can't exercise because of my breathing Wake up at night
Have you gone to the ER or urgent care in past year because of breathing issues? ____ Yes _____No
Have you ever been admitted to the hospital for breathing issues? ____ Yes _____No
What triggers your breathing symptoms? Cold symptoms Pollen Animals Exercise Cold air Tobacco smoke Changes in weather Strong scents/odors (perfumes) Taking aspirin or ibuprofen

ALLERGIES (INDOOR/OUTDOOR) ____ YES _____NO
How long have you had allergy symptoms? _____ **How long have you lived in area?** _____
Circle all allergy symptoms you have:
Nasal symptoms: Congestion Runny nose Sneezing Itching Post-nasal drip Decreased / Loss of sense of smell
Eye symptoms: itching watery redness
Breathing Symptoms: Cough Wheeze Shortness of breath Chest tightness
What seasons do you have allergy symptoms: Year-round Spring Summer Fall Winter
What triggers your symptoms? Pollen Cat Dog Exercise Cold air Tobacco smoke Changes in weather Strong scents/odors
Where are you living: Single Family Home (Yr Built: _____) Apartment /Condo Mobile Home Other:_____
Present in home: Central heat/air conditioning Wood burning stove/fireplace Mold / water damage Musty smell
Carpeting (bedroom ____Yes ____No) Tile Laminate Hardwood
Air purifier Dust mite covers: mattress / pillowcase Humidifer
Pets: Dog Cat Other:_____
Are pets allowed in bedroom: _____ Yes _____ No

FOOD ALLERGIES ____ YES _____NO
Which food(s) are you concerned about? _____
How long ago was this reaction? _____ How soon after you ate the food did you start to have symptoms? _____
What symptoms did you have when you ate the food?
Skin: redness itching hives swelling of lips or tongue
Nose/eyes: runny nose stuffiness sneezing eye swelling eye itching
Breathing: cough wheeze shortness of breath chest tightness
Stomach: cramping nausea vomiting diarrhea
Other: passed out change in voice feeling a lump in the back of the throat

ALLERGIES (INSECT) ____ YES _____NO
Which insect(s) are you concerned about? _____
How long ago was the reaction? _____ How soon after you were stung did you start to have symptoms? _____
What symptoms did you have when you were stung?
Skin: redness itching hives swelling of lips or tongue
Nose/eyes: runny nose stuffiness sneezing eye swelling eye itching
Breathing: cough wheeze shortness of breath chest tightness
Stomach: cramping nausea vomiting diarrhea
Other: passed out feeling a lump in the back of the throat metallic taste need to shower

If your Allergy-related concern isn't listed above, please list it here: _____

_____

_____

REVIEW OF SYSTEMS – PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING IN THE LAST <u>4 WEEKS:</u>

FEVER NIGHT SWEATS UNINTENTIONAL WEIGHT LOSS _____lbs FATIGUE HEADACHE

NAUSEA VOMITTING DIARRHEA ABDOMINAL PAIN

HIVES DRY OR ITCHY SKIN SKIN RASH

DO YOU HAVE A HISTORY OF RECURRENT INFECTIONS: ____ YES _____NO
PLEASE CIRCLE WHICH TYPE: SINUS EAR THROAT SKIN
PNEUMONIA BRONCHITIS