Allergy & Asthma Clinic of San Antonio

Adult & Pediatric

www.allergyasthmasa.com

NEW PATIENT ALLERGY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Sex: ☐ M ☐ F Pregnant? ☐ N/A ☐ Yes ☐ No ☐ Unsure Last Menstrual Period: _____

Primary Doctor: _____ Referring Doctor: _____

Current Occupation: _____ Hobbies: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other: _____

What problems are here to have evaluated?: (check all that apply)

☐ Nasal Allergies/Hay Fever	☐ Hives	☐ Bronchitis (chronic or recurrent)
☐ Sinus/ Nose Problems	☐ Angioedema (swelling)	☐ Cough (chronic or recurrent)
☐ Eye Problems	☐ Eczema (dry, itchy skin)	☐ Recurrent respiratory infections
☐ Ear Problems	☐ Medication Allergy/ Reaction	☐ Reaction to insect sting/bite
☐ Asthma/ Wheezing	☐ Food Allergy/Reaction	☐ Other: _____

What triggers your symptoms?

_____

_____

Check which months in which your symptoms are worse:

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

Are you allergic to any medications? _____

When you had reaction: ☐ Child ☐ Adult

Symptoms: ☐ Rash ☐ Hives ☐ Cough ☐ Swelling ☐ Anaphylaxis ☐ Shortness of Breath ☐ Stomach Ache ☐ Other: _____

Are you allergic to any foods? _____

When you had reaction: ☐ Child ☐ Adult

Symptoms: ☐ Rash ☐ Hives ☐ Cough ☐ Swelling ☐ Anaphylaxis ☐ Shortness of Breath ☐ Stomach Ache ☐ Other: _____

Are you allergic to insect bites? ☐ Yes ☐ No _____

Symptoms: ☐ Rash ☐ Hives ☐ Cough ☐ Swelling ☐ Anaphylaxis ☐ Shortness of Breath

Previous Allergy Care: Check all that apply: ☐ Never tested before

☐ Tested before ☐ Skin ☐ Blood Positive for: _____

☐ Allergy shots Dates: _____ - _____ Degree of help: ☐ Little ☐ Some ☐ A lot

List all medications and treatments *(prescription, over-the-counter and /or homeopathic)* that you have used for your symptoms, including any side effects you experienced *(drowsiness, blurred vision, dry mouth, dizziness, constipation, etc…)*:

Name of Medicine	**Did it help?**	**Side Effects**
_____	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	_____

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Check the appropriate symptoms for each problem:

Skin:	☐ Itching ☐ Welts ☐ Dry Skin ☐ Eczema ☐ Blisters ☐ **Rash** (location):_____ ☐ Bumpy ☐ Scaly ☐ Red ☐ Raised	
	If you suffer from recurrent hives or swelling please answer the following:	
	☐ **Hives**	Frequency: _____ per week/month/year Duration of each episode:_____ minutes/hours/days
	☐ **Swelling** location:_____	Frequency: _____ per week/month/year Duration of each episode:_____ minutes/hours/days
	Precipitating factors:	☐ unknown ☐ exercise ☐ food (specify): _____ ☐ medications (specify): _____
	Exposure to:	☐ cold ☐ heat ☐ sunlight ☐ physical pressure ☐ Other:_____
	Contact with:	☐ animals ☐ plants ☐ chemicals ☐ Other:_____
Nose:	☐ Sneezing ☐ Itching ☐ Stuffy ☐ Sniffling ☐ Snoring ☐ Bleeding ☐ Nasal Polyps ☐ Runny Nose ☐ Post-nasal drip ☐ Mucus:	
Sinus:	☐ Congestion ☐ Drainage ☐ Sinus headaches ☐ Snoring ☐ Sinus infections (frequency:_____ times per year) ☐ Ear Tubes (type/dates:_____)	
Ears:	☐ Plugged ☐ Popping ☐ Fluid in ears ☐ Itching ☐ Hearing loss ☐ Ringing ☐ Infections (frequency:_____ times per year) ☐ Ear Tubes (dates:_____)	
Eyes:	☐ Itching ☐ Watery ☐ Redness ☐ Dark circles under eyes	
Respiratory: (Chest)	☐ Asthma ☐ Wheezing ☐ Shortness of breath ☐ Chest tightness ☐ **Cough:** ☐ dry ☐ congested **Worse** ☐ with exercise ☐ at night ☐ Other:_____ ☐ **Phlegm:** ☐ clear ☐ white ☐ yellow ☐ green ☐ brown ☐ bloody ☐ Other:_____ ☐ Pneumonia(s) (date(s):_____) ☐ frequent bronchitis (frequency: _____ episodes per year)	
	If you suffer from asthma or asthma symptoms, please answer the following:	
	Do you have asthma symptoms at rest? ☐ No ☐ Yes, _____ times per week/month/year Do you have asthma symptoms with exercise? ☐ No ☐ Yes Do you have a home nebulizer? ☐ No ☐ Yes *If yes, how often do you use it?* _____ How much school/work missed due to asthma or asthma symptoms? _____ days per year	
	Have you ever required…. Cortisone, prednisone or steroids (tablets or injections)? Visits to the emergency room for asthma/ asthma symptoms? Hospitalization for asthma or asthma symptoms? Hospitalization in an intensive care unit? Artificial respiration or ventilation? Nebulizer treatment in a doctor's office?	 ☐ No ☐ Yes #___courses per year ☐ No ☐ Yes #___visits per year ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes
	Date of last chest x-ray:_____ ☐ N/A	Date of last sinus x-ray:_____ ☐ N/A
Infectious Disease	☐ Meningitis ☐ Recurrent skin infections ☐ Other:_____ Frequency: _____ episodes per year	

M.D. Notes:_____

Environmental Survey

Question	Answer	Question	Answer
Do you have any pets? Type:_____	☐ Yes ☐ No	Are there any smokers in the home?	☐ Yes ☐ No
Are the pets indoors?	☐ Yes ☐ No	Do you have indoor plants?	☐ Yes ☐ No
Are you exposed to any other animals regularly?	☐ Yes ☐ No	Do you have any air filtration system?	☐ Yes ☐ No

Current Residence:	City:_____ Time living here:_____
Home type:	☐House ☐Condo ☐Apt ☐Mobile Home ☐College ☐Other: _____
Home location:	☐Urban ☐Suburban ☐Rural ☐Agricultural ☐Industrial ☐Other: _____
Type of Flooring:	☐Carpet ☐Tile ☐Wood ☐Linoleum ☐ Concrete ☐Other: _____
Type of Bed:	☐ Mattress/ Box spring ☐Waterbed ☐Bunk Bed ☐ Futon ☐Other: _____
Type of Pillow:	☐Polyester ☐ Foam ☐Feather ☐ None ☐Other: _____
Air Conditioning/ Heating:	☐Central A/C ☐Window Unit A/C ☐Gas Heating ☐Electrical Heating ☐Radiator ☐No A/C or Heating ☐Other: _____

Past Medical History: *Please check all problems you are currently or have previously experienced.*

☐ High Blood Pressure	☐ Liver Disease	☐ Gastric ulcer	☐ Hepatitis
☐ Heart Disease	☐ Kidney Disease	☐ Hiatal Hernia	☐ Emphysema/COPD
☐ Mitral Valve Prolapse	☐ HIV positive	☐Gastroesophageal reflux	☐ Diabetes
☐ Heart murmur	☐ AIDS	☐Mononucleosis	☐ Cancer
☐Abnormal Heart rhythm	☐ Rheumatoid arthritis	☐ Prostate Infection	☐ Tuberculosis
☐Anemia	☐ Arthritis	☐Depression	☐ Positive PPD
☐ Migraine Headaches	☐Lupus	☐Hyperactivity	☐ Thyroid Disease
☐ Seizures or Epilepsy	☐ Glaucoma	☐ Alcohol/Drug Addiction	☐Other: _____

Past Surgeries? ☐ Tonsils ☐ Adenoids ☐ Nose ☐ Sinuses ☐Heart ☐ Gall Bladder ☐ Hysterectomy ☐ Breast ☐ Prostrate ☐Other: _____

Hospitalizations/Emergency Room Visits: When?_____ For? _____
When?_____ For? _____

Current Medications- *List all medications that are you currently taking for any reason*

	Medications	**Dose**	**Reason for Taking**
1.			
2.			
3.			
4.			
5.			

M.D. Notes:_____

Social History

Do you smoke cigarettes? ☐ No ☐ Yes How much? If yes, how much? _____
Have you smoked cigarettes before? ☐ No ☐ Yes If yes, how much? _____
Year you smoking:_____ ☐ N/A Year quit smoking: _____ ☐ N/A
Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, how much? _____
Do you use non-prescription drugs? ☐ No ☐ Yes If yes, which ones? _____

Family History – Select all that apply and indicate which family member has the problem.

F- Father **M**-Mother **C**-Children **B**-Brother **S**-Sister **G**-Grandparents

_____Hay Fever _____Food Allergies _____Asthma _____Eczema _____Sinusitis
_____Diabetes _____High Blood Pressure _____Glaucoma _____Other: _____

M.D. Notes:_____