Comprehensive Allergy & Asthma Care **Allergy/Immunology Evaluation**
Name__________________________ **DOV_______________**

Information provided by this questionnaire will be of major assistance to the doctor in helping you. Please take the time to complete this questionnaire before your appointment.

Patient Name: ____________________________________
Date of Birth: ____________________________________
Primary Care Physician (first & last name):___________________________
Referring Physician: ______________________________
Pharmacy____________________________

What is the major reason for your visit today?

When did the symptoms start?

What have you done that has reduced the symptoms/feel better?

• Hay fever/Allergic Rhinitis	• Hives/Skin Swelling Episode
• Rash/Eczema	• Nasal Congestion/ Draining Mucus in Throat (post nasal drip)
• Sinus Problems	• Food Allergy/Food Reaction
• Insect Sting Reaction	• Recurrent Infections
• Headaches	• Joint Pain
• Drug Reaction	• Cough
• Asthma/Trouble Breathing	• Intestinal Problems- Bloating/Diarrhea/Constipation
• Other	

Triggers: What make your symptoms worse? (Check all that apply)

___ House Cleaning	___ Being outdoors
___ Making the bed	___ Being indoors
___ Lawn mowing	___ Cool air
___ Raking Leaves	___ Warm air
___ Moldy or damp areas	___ Cat dander
___ Clear weather	___ Dog dander
___ Colds or flu-like symptoms	___ Other animals_______________
___ Smoke	___ Medications________________
___ Perfumes	___ Aspirin
___ Hair sprays	___ Ibuprofen(Advil/Motrin)
___ Soap powders	___ Naprosyn(Aleve)
___ Laughing or crying	___ Foods
___ Exercise	Nuts Dairy
___ Lying down	Fruits/Vegetables
___ Getting up in the morning	Wheat/Grains
	Other____________________

Office Use Only

Height: _____

Weight: _____

BP: ___/_____

Pulse: _______

Spirometry
FEV1________( )
FVC________( )
PEF________( )
EF25-75 _____( )

POST – SABA
FEV1________( )
FVC________( )
PEF________( )
EF25-75 ________( )

FENO______________

Comprehensive Allergy & Asthma Care **Allergy/Immunology Evaluation**

Name__________________________ **DOV________________**

Question	
Any odd physical reactions or feeling nauseous or 'off' after ingesting any foods or drinks? Which foods or drinks?	
Any unusual physical responses to stress, exercise or social gatherings?	
Any episodes feeling lightheaded, shaky, weak?	
Any shortness of breath, wheezing or cough at any time? Did anything specific precede it? (eating, exercising, etc.)	
Any unusual physical responses (rash? Dizziness? Trouble breathing, e.g.) to temperatures while showering/bathing? from changes in the weather/ indoor temperatures?	
Any changes in memory, learning, retention, mental processing, understanding? Suspected triggers?	
Any musculoskeletal pain or joint problems? Which parts of your body are affected? Is it persistent or intermittent?	
Any unusual fatigue? Fainting? Does occur during or after certain activities (eating, drinking, exercise?)	
Any skin spots, rashes, blotches, hives, sores, itching episodes?	
Any extreme or unusual reactions to insect bites (mosquito/ wasps/bees/hornets)? Please describe the reaction.	
Do you have a headache disorder? If so, which type of headaches stress/tension/migraine/sinus?	
Any unusual fluctuations or changes in hearing?	
Any unusual fluctuations or changes vision quality?	
Any physical reaction to clothing, fabrics, pressure or tight fabrics against skin? Or from contact with new furniture, materials or plastics?	
Any unexplained weight loss? Inability to put weight back on?	
Any unexplained weight gain? Inability to lose weight?	
Any odd reactions to medications?	
Any odd reactions to any medical procedures or tests?	
For women or young girls entering puberty, any difficulty with monthly menstrual cycles?	
Any emergency medical situations experienced, and, if so, what caused or precipitated the emergency?	

Comprehensive Allergy & Asthma Care **Allergy/Immunology Evaluation**
Name__________________________ **DOV________________**

Review of Symptoms: Please check symptoms that you have experienced within the past 3 months.

General	__Fever __Chills __Loss of appetite __Increased appetite __Weight loss (unintended) __Weight gain __Night Sweats
Eyes	__Itch __Pain __Excessive tears __Dry eyes __Loss of Vision
Ears/Nose/Throat	__Congestion __Sinus problems __Hoarse voice __Sore throat __Dry nose __Runny nose __Nosebleeds __Ringing in ear __Ear pain __Loss of hearing __ mucus in throat
Heart	__Chest pain __Irregular/skipped heart beats ___Fast Heart Beats/palpitations
Respiratory	__Cough __Wheeze __Shortness of breath __ Difficulty take a deep breath in
Urinary Tract	__Difficulty urinating __Pain urinating __ Recurrent Urinary Tract Infections
Skin	__Rash __Itch __Hives/Welts __Swelling __Hair loss
Endocrine	__Sensitive to the cold __Sensitive to the heat __ Feel the need to drink lots of water __ For young ladies/women-abnormal period/menses
Neurology	__Headaches __Weakness __Seizures __dizziness
Mood	__Sleeping poorly __Anxious __Depressed

Comprehensive Allergy & Asthma Care **Allergy/Immunology Evaluation**
Name_________________________ **DOV_______________**

Allergy History

Have you ever been diagnosed with asthma, allergic rhinitis (hay fever "allergies") or eczema?	__Yes	__No
When you were a young child, did you have allergies, asthma, or eczema?	__Yes	__No
Have you ever been on allergy immunotherapy/shots?	__Yes	__No
Have you ever had a reaction to food? Which: Nuts / Shellfish / Fresh Fruit / Soy / Wheat	__Yes	__No
Have you ever had a reaction to latex?	__Yes	__No
Have you ever had a reaction to insect sting?	__Yes	__No
Have you ever been allergy tested, skin or blood? Allergic to pollen/dust/mold/animals	__Yes	__No

When and what were you allergic to?___________________________________

If you do have allergies, what medications have you tried, and did they help?
____

Any Medication Allergies or Adverse Reactions?

Medication	Reaction

Have you ever been hospitalized overnight for reasons other than surgery?
If so, please list:
____
____

Any Surgeries you have had in the past:

___ Sinus	__ Tonsils	__ Adenoids	__ Orhopedic	__Other__________

Comprehensive Allergy & Asthma Care **Allergy/Immunology Evaluation**
Name__________________________ **DOV________________**

Immune System: In the past have you been treated for frequent or recurrent infections?:
___ Four or more new ear infections within 1 year.
___ Two or more serious sinus infections within 1 Year.
___ Two or more months on antibiotics with little effect.
___ Two or more pneumonias within 1 year.
___ Failure of an infant to gain weight or grow normally.
___ Recurrent, deep skin or organ infections / abscesses.
___ Persistent thrush in mouth or fungal infection on skin.
___ Need for intravenous antibiotics to clear infections.
___ Two or more deep-seated infections including septicemia.

How long have you had your symptoms? ______________________________

Are your symptoms getting worse? ___ Yes ___ No

Are your symptoms (check one):

___ Present all year but worse at certain times of the year?
___ Coming and going without apparent relation to the time of the year?
___ Only at certain times of the year?

Circle the months which you are worse:

Winter:	DEC	JAN	FEB
Spring:	MAR	APRI	MAY
Summer:	JUN	JUL	AUG
Fall:	SEP	OCT	NOV

Do you have to miss school or work because of allergy symptoms?
___ None ___ Occasionally ___ Frequently

Do your symptoms disturb your sleep?
___ None ___ Occasionally ___ Frequently

Are you worse? (Check all that apply)
___ Indoors ___ Outdoors ___ At home ___ At work ___ on vacation

Comprehensive Allergy & Asthma Care **Allergy/Immunology Evaluation**

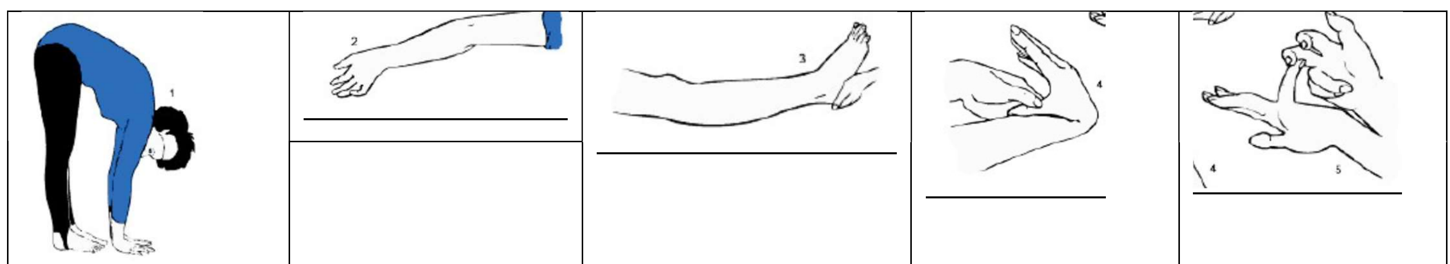
Name__________________________ **DOV_______________**

Past Medical History:

What medical problems have you been treated for in the past?

	Current	Past
Eye Disease		
Respiratory Infections		
Ear Infections		
Sinus Problems		
Pneumonia		
Asthma		
Bronchitis		
Heartburn		
Anemia		
Migraine/Headache		
Hypertension		
Arthritis		
Thyroid Disorder		
Cancer		
Diabetes		
Eczema		
Skin Infections		
Liver Disease		
HIV/AIDS		

Evaluation of Joint Hypermobility	**Yes**	**No**
Can you now (or could you ever) place your hands flat on the floor without bending your knees?		
Can you now (or could you ever) bend your thumb to touch your forearm?		
As a child, did you amuse family or friends by bending your body into strange shapes?		
As a child, could you do a split?		
Have you ever have your shoulder, knee cap or hip dislocate (slip out & pop back into place) on more than one occasion?		
Do you consider yourself double jointed?		



Comprehensive Allergy & Asthma Care **Allergy/Immunology Evaluation**

Name________________________ **DOV_______________**

Environmental History

Do you live in:	__Single Family	__Apartment	__Condo
Occupation		**Hobbies**	
Carpeting in:	__Bedroom	__Playroom	
Do you have mold in:	__Basement	__Bathroom	
Pets?	__Cat	__Dog	Other _________
Do you smoke?	__Never	__Former	__Current
Air Conditioning in:	__Bedroom		

	No	**Yes**, how much did/do you use…
Do you have a history of alcohol use?		
Do you have a history of drug abuse?		

Current Medications?	**How Much?**	**How Often?**

Comprehensive Allergy & Asthma Care **Allergy/Immunology Evaluation**

Name_________________________ **DOV_______________**

Please check which family member may have been treated for the following conditions:

	Mother	Father	Sister	Brother	Maternal Grand-Mother	Maternal Grand-father	Paternal Grand-Mother	Paternal Grand-Father	Aunt (M/P)	Uncle (M/P)
Allergies										
Sinus Problems										
Pneumonia										
Asthma										
Bronchitis										
Heartburn										
Nasal polyps										
Migraine/Headache										
Hypertension										
Arthritis										
Thyroid Disorder										
Cancer										
Diabetes										
Eczema										
Skin Infections										
Autoimmune Disorders										

Patient Name:	**Patient Signature:**	**Date:**
Physician Name:	**Physician Signature:**	**Date:**