# Comprehensive Allergy & Asthma Care – New Patient Intake

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: ___________________________________________
Name and tel. # of Primary Care Physician: ____________________

Name and tel. # of Referring Physician: ______________________

What do you hope to achieve in your visit with us today?

What three problems bother you the most?

1. ____________________________________________________________________

2. ____________________________________________________________________

3. ____________________________________________________________________

When was the last time you felt well?________________________________________

Did some event/something trigger your change in health? __________________________

What makes you feel worse? _____________________________________________

What makes you feel better? _____________________________________________

**Office Use Only**

Height: ______

Weight: _____

BP: ___/_____

Pulse: _______

Pre

FEV1________( )
FVC________( )
PEF________( ) EF25-75
______( )

Post

FEV1________( )
FVC________( )
PEF________( )

EF25-75 ______( )

Comprehensive Allergy & Asthma Care – New Patient Intake

## Allergy History

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

| Screening for breathing difficulties:<br>Please Answer the following Questions: | Check All that Apply |
|---|---|
| Have you ever had trouble with your breathing? (continuously or repeatedly) | |
| Have you had an attack/episode of shortness of breath at any time in the last 12 months? | |
| Have you had wheezing or whistling in your chest at any time in the last 12 months? | |
| Have you been awakened during the night by an attack of any of the following symptoms in the last 12 months: (a) cough? (b) chest tightness? | |
| Have you been given an inhaler by a doctor to help your breathing? | |

When was the testing _______ , (circle blood tests or skin testing) and what were you allergic to?___
foods___________________________________
airborne___________________________________

**Office Use Only**

**Any Medication Allergies or Adverse Reactions?**
**Do you tolerate anesthesia or pain medications?**

| Medication | Reaction: (Rash? Headache? Diarrhea? Anaphylaxis? |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Triggers:** Things or exposures that 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 | ___ Anesthesia |
| ___ Perfumes | ___ Aspirin |
| ___ Hair sprays | ___ Ibuprofen(Advil/Motrin) |
| ___ Soap powders | ___ Naprosyn(Aleve) |
| ___ Laughing or crying | ___ Lying down |
| ___ Exercise | ___ Infections |
| | ___ Getting up in the morning |
| | ___ for women: menstrual period? |

**Office Use Only**

Comprehensive Allergy & Asthma Care – New Patient Intake

| Please check all that apply | Tell us about your past health/illnesses |
|---|---|
| | Severe headaches/ Frequent headaches |
| | Stroke |
| | Back Pain |
| | Personal Injury/Accident |
| | Joint Pain/Arthritis |
| | Fainting spells |
| | Seizure/ Epilepsy |
| | Heartburn/Gastro-esophageal Reflux |
| | Irritable bowel Syndrome<br>Diarrhea? Constipation? |
| | IBD: Crohn's Disease? Colitis? |
| | Kidney Problems |
| | Bladder Problems |
| | Cough |
| | Asthma/Trouble Breathing |
| | Liver problems / Hepatitis |
| | Sinusitis |
| | Eye or Vision Problems: Itch? Pain? Loss of Vision? |
| | Throat infections |
| | Ear Infections |
| | Other infections |
| | Rheumatic Fever |
| | Heart Problems________________ Valve disorder |
| | Hypertension? |
| | Low blood pressure? |
| | Food Allergy<br>Colic as a baby? |
| | Eczema: Allergic? Contact dermatitis? |
| | Skin Infections |
| | Hayfever/Allergic Rhinitis |
| | Nasal Polyps |
| | Cancer, if so what type_______________ |
| | Psoriasis |
| | Lupus |
| | Autoimmune Disorder_____________ |

**Office Use Only**

| Screening questionnaire for an immune deficiency syndrome/disorder | Please Check all that apply |
|---|---|
| Have you or your child been treated for 4 or more new ear infections within 1 year? | |
| Have you or your child been treated for 2 or more serious sinus infections within 1 year? | |
| Have you or your child received 2 or more months on antibiotics with little effect? | |
| Have you or your child been treated for Two or more pneumonias within 1 year? | |
| Did you or your child have a history of failure of an infant to gain weight or grow normally? | |
| Have you or your child been treated for recurrent, deep skin or organ abscesses? | |
| Have you or your child been treated for persistent or recurrent thrush in mouth or fungal infection on skin | |
| Have you or your child needed for intravenous antibiotics to clear infections? | |
| Have you or your child been treated for 2 or more deep-seated infections including septicemia (blood infection)? | |
| Have you ever been evaluated for recurrent fevers (fevers of unknown origin)? | |
| Has a family member been treated for recurrent or severe infections, diagnosed with primary immune deficiency disorder? | |

Have your medications or supplements ever caused you unusual side effects or problems?
Describe: ______________________________________________________________________

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin?

Have you had prolonged or regular use of Tylenol?

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)
Frequent antibiotics > 3 times/year

Long term antibiotics To treat what illness? ____________________________

Use of steroids (prednisone, nasal allergy inhalers) in the past

Use of oral contraceptives?

Sleep Evaluation:

Average number of hours you sleep per night:
__>10 ☐
__8-10
__6-8
__< 6

Do you have trouble falling asleep?

Do you feel rested upon awakening?

Do you have problems with insomnia?

Do you snore?

Do you use sleeping aids?
Explain:
______________________________________________________________________________

| Please check all that apply | Assessment of Joint Hypermobility/Flexibility |
|---|---|
| | 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 contorting (bending) your body into strange shapes or could you do splits? |
| | As a child or teenager, did your shoulder, hip or knee cap dislocate (slip out and pop back into place) on more than one occasion? |
| | Do you consider yourself double jointed? Which Joints |

## Surgeries

Check box if yes and provide date (year) of surgery

Adenoid Removal __________
Appendectomy __________
Hysterectomy +/- Ovaries ______
Gall Bladder ___________
Hernia _______
Tonsillectomy ___________________
Dental Surgery ___________________
Joint Replacement –Knee/Hip _______
Orthopedic ________________
Neurosurgery ________________
Heart Surgery–Bypass Valve _________
Angioplasty or Stent ________
Pacemaker ________________
Other ________________

| Medications (prescription, OTC) | How Much | How Often | Helpful? |
|---|---|---|---|
| | | | |

| **Supplements** | **How Much** | **How Often** | **Helpful?** |
|---|---|---|---|
| | | | |

**Environmental History**

| **Do you live in:** | __Single Family | __Apartment | __Condo |
|---|---|---|---|
| **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 | | |
| **Fireplace in the home?** | __ yes __no | | |
| **In your home or workplace, Any problems with…** | __mice | _roaches | __beetles |

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

**ROLES/RELATIONSHIPS**

Marital status:
__Single __Married __Divorced __Gay/Lesbian __Long Term Partnership __Widow

| Child's Name | Age | Gender |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Who is Living in Household? Number: _______

Names:_______________________________________________________________________________

Their employment/Occupations:________________________________________________________
Resources for emotional support?

*Check all that apply:*

_Spouse _Family _ Friends _ Religious/Spiritual _ Pets _ Other: _________________

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

| | |
|---|---|
| General | ☐ Cold Intolerance<br>☐ Low Body Temperature<br>☐ Low Blood Pressure<br>☐ Daytime Sleepiness<br>☐ Difficulty Falling Asleep<br>☐ Early Waking<br>☐Fatigue<br>☐ Fever<br>☐ Flushing<br>☐ Heat Intolerance<br>☐ Night Waking<br>☐ Nightmares<br>☐ No Dream Recall |
| Eyes | ☐ Itching ☐ Tearing<br>☐ Dry Eyes<br>☐ Lid Margin Redness<br>☐ Eye Crusting<br>☐ Eye Pain<br>☐ Vision problems (other than glasses)<br>☐ Macular Degeneration<br>☐ Vitreous Detachment<br>☐ Retinal Detachment |
| Ears/Nose/Throat | ☐ Hoarseness ☐ Sore Throat<br>☐ Nasal Stuffiness ☐ Snoring<br>☐ Nose Bleeds ☐ Post Nasal Drip<br>☐ Sinus Fullness ☐ Sinus Infection<br>☐ Distorted Sense of Smell<br>☐ Distorted Taste<br>☐ Ear Fullness ☐ Ear Pain<br>☐ Ear Ringing/Buzzing<br>☐ Hearing Loss ☐ Hearing Problems<br>☐ Headache<br>☐ Migraine<br>☐ Sensitivity to Loud Noises |
| Heart | ☐ Angina/chest pain<br>☐ Breathlessness<br>☐ Heart Murmur<br>☐ Irregular Pulse<br>☐ Palpitations<br>☐ Phlebitis<br>☐ Swollen Ankles/Feet<br>☐ Varicose Veins |
| Respiratory | ☐ Cough-Productive<br>☐ Wheezing<br>☐ Winter Stuffiness |
| Gastrointestinal tract | _ ☐ Bleeding Gums<br>***Bloating of:***<br>☐ Lower Abdomen<br>☐ Whole Abdomen<br>☐ Bloating After Meals<br>☐ Blood in Stools<br>☐ Burping<br>☐ Canker Sores<br>☐ Cold Sores<br>☐ Constipation<br>☐ Cracking at Corner of Lips<br>☐ Cramps<br>☐ Dentures w/Poor Chewing<br>☐ Diarrhea<br>☐ Alternating Diarrhea and Constipation |

| | |
|---|---|
| | ☐ Difficulty Swallowing<br>☐ Dry Mouth<br>☐ Excess Flatulence/Gas<br>☐ Fissures<br>☐ Foods "Repeat" (Reflux)<br>☐ Gas<br>☐ Heartburn<br>☐ Hemorrhoids<br>☐ Indigestion<br>☐ Nausea<br>☐ Upper Abdominal Pain<br>☐ Vomiting<br>☐ Liver Disease/Jaundice (Yellow Eyes or Skin)<br>☐ Abnormal Liver Function Tests<br>☐ Lower Abdominal Pain<br>☐ Mucus in Stools<br>☐ Periodontal Disease<br>☐ Sore Tongue<br>☐ Strong Stool Odor<br>☐ Undigested Food in St<br><br>☐ Can't Lose Weight<br>☐ Can't Maintain Healthy Weight<br>☐ Frequent Dieting<br>☐ Poor Appetite<br>☐ Salt Cravings<br>☐ Carbohydrate Craving (breads, pastas)<br>☐ Sweet Cravings (candy, cookies, cakes)<br>☐ Chocolate Cravings<br>☐ Caffeine Dependency |
| Urinary Tract | ☐ Bed Wetting<br>☐ Hesitancy (trouble getting started)<br>☐ Infection<br>☐ Kidney Disease<br>☐ Leaking/Incontinence<br>☐ Pain/Burning<br>☐ Prostate Infection<br>☐ Urgency |
| **Musculoskeletal** | ☐ Back Muscle Spasm<br>☐ Calf Cramps<br>☐ Chest Tightness<br>☐ Foot Cramps<br>☐ Joint Deformity<br>☐ Joint Pain<br>☐ Joint Redness<br>☐ Joint Stiffness<br>☐ Muscle Pain<br>☐ Muscle Spasms<br>☐ Muscle Stiffness<br>☐ Muscle Weakness<br>☐ Neck Muscle Spasm<br>☐ Tendonitis<br>☐ Tension Headache<br>☐ TMJ Problems |
| Skin | __Rash __Itch<br>__Hives/Welts __Swelling<br>__Hair loss ____ Excessive sweating |

| Endocrine | __sensitive to the cold<br>__sensitive to the heat<br>__feel the need to drink lots of water<br>__ women: abnormal menstrual period |
|---|---|
| Neurology/ Mood | ☐ Anxiety<br>☐ Auditory Hallucinations<br>☐ Black-out<br>☐ Depression<br><br>***Difficulty:***<br>☐ Concentrating ☐ With Balance<br>☐ With Thinking ☐ With Judgment<br>☐ With Speech ☐ With Memory<br><br>☐ Dizziness (Spinning)<br>☐ Fainting<br>☐ Fearfulness<br>☐ Irritability<br>☐ Light-headedness<br>☐ Numbness<br>☐ Other Phobias<br>☐ Panic Attacks<br>☐ Paranoia<br>☐ Seizures<br>☐ Suicidal Thoughts<br>☐ Tingling<br>☐ Tremor/Trembling<br>☐ Visual Hallucinations |
| | |

# Comprehensive Allergy & Asthma Care – New Patient Intake

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

| | Mother | Father | Son | Daughter | Brother | Sister | maternal Grand-Mother | maternal Grand-Father | paternal Grand-Mother | paternal Grand-Father | Aunt/Uncle (maternal or paternal) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Food Allergy<br>Rhinitis<br>Eczema | | | | | | | | | | | |
| Sinus Problems/Polyps | | | | | | | | | | | |
| Pneumonia | | | | | | | | | | | |
| Asthma | | | | | | | | | | | |
| Bronchitis | | | | | | | | | | | |
| Heartburn | | | | | | | | | | | |
| Irritable bowel Syn.? | | | | | | | | | | | |
| Migraine/Headache | | | | | | | | | | | |
| Hypertension | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | |
| Stroke | | | | | | | | | | | |
| Arthritis | | | | | | | | | | | |
| Thyroid Disorder | | | | | | | | | | | |
| Cancer<br>Breast?<br>Prostate?<br>Colon?<br>Other___________ | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | |
| Eczema | | | | | | | | | | | |
| Connective Tissue Disorder? EDS? | | | | | | | | | | | |
| Celiac Disease | | | | | | | | | | | |
| Mood Disorders<br>-Anxiety<br>-Depression | | | | | | | | | | | |
| Autoimmune disorder:<br>Rheumatoid arth.?<br>Lupus?<br>Psoriasis? | | | | | | | | | | | |