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NEW PATIENT QUESTIONNAIRE

To be filled out by the patient or the patient/guardian of the minor child. The following questions will help to determine the cause of your allergy symptoms. It is important to check (❒)each question to the best of your knowledge and as accurately as possible.

Name: ____ **DOB:** ________ **Age:** _____

Date: ____________________________ **Date – Last Antihistamine:** _______________________

Previous Allergy Workup? _______ **Year Tested?** ____________ **Immunotherapy?** __________

Referring Physician: ____

Please check what applies to you:

General:
- ❒ Weight: Gain or Loss
- ❒ Tired all the time

Skin:
- ❒ Rash (where ______)
  - ❒ Soap
  - ❒ Contact
- ❒ Hives
- ❒ Eczema, boils, infections
- ❒ Dryness, itching
- ❒ Insect bite reaction

Head:
- ❒ Headache (where ______)
- ❒ Head injury (when ______)

Eyes:
- ❒ Strain, change in vision
- ❒ Redness, puffiness, discharge
- ❒ Itching, rubbing

Ears:
- ❒ Pain, discharge
- ❒ Itch, popping
- ❒ Infections, hearing loss

Nose:
- ❒ Frequent colds
- ❒ Discharge
- ❒ Clear / Discolored
  - ❒ Thin / Thick
  - ❒ Constant / Seasonal
- ❒ Itching, rubbing, picking
- ❒ Stuffiness (constant / seasonal)
- ❒ Sneezing
- ❒ Sniffling, snoring, bleeding
- ❒ Change in smell

Throat:
- ❒ Sore, itch
- ❒ Trouble swallowing
- ❒ Clearing throat, hoarseness
- ❒ Post nasal drip (clear / white / other)

Respiratory:
- ❒ Wheeze (with rest / with activity)
- ❒ Cough (day / night, with exercise)
  - ❒ Dry ❒ Wet
- ❒ Chest tightness
- ❒ Shortness of breath

CONTINUE⟶

Patient Name: ____ **Date:** ____________

Symptoms:

Symptoms worse: ❒ indoor ❒ outdoor ❒ home ❒ work ❒ morning ❒ afternoon ❒ night
Symptoms worse in what season: ❒winter ❒ spring ❒ summer ❒ fall

Symptoms Triggers:

❒ smoke ❒ perfume ❒ hair spray ❒ paint ❒ cosmetics ❒ insecticides ❒ chemicals ❒ fumes
❒ detergent ❒ hay ❒ grass ❒ dust ❒ damp areas ❒ animal: specify ______________________________
❒ food: specify ____ ❒ alcohol
❒ cold day ❒ hot day ❒ windy day ❒ weather change ❒ air conditioning ❒ intense laughing/crying
❒ medication: specify____

Living Accommodations:

❒ House ❒ Apartment (age of building ___________) Present address for __________ years.
Location: ❒ city ❒ suburb ❒ country/farm ❒ Recent painting or repairs.
Slab/basement: ❒ finished ❒ dry ❒ damp ❒ mildew
Flooring: ❒ hardwood in the bedroom ❒ carpet in the bedroom ❒ wool ❒ synthetic
Padding: ❒ rubber ❒ ozite ❒ other

Furniture:

❒ new ❒ mohair

Window treatment:

❒ drapes ❒ blinds ❒ shades

Heating system:

❒ hot air ❒ hot water ❒ electric baseboard
Fuel: ❒ gas ❒ electric ❒ coal ❒ oil ❒ other _____________________________________
Air filters: ❒ fiberglass ❒ electrostatic ❒ HEPA ❒ other
Air conditioning: ❒ central ❒ window unit ❒ Humidifier ❒ Dehumidifier
Usual house temperature: Day ______________________ Night ______________________
Bedroom windows open: ❒ day ❒ night ❒ winter ❒ summer

Bedding:

Mattress: ❒ regular ❒ synthetic ❒ waterbed.
Mattress cover: ❒ cotton pad ❒ allergy proof *Box spring cover:* ❒ cotton ❒ allergy proof
Pillows: ❒ feather ❒ polyester ❒ kapok ❒ allergy proof.
Blanket: ❒ wool ❒ cotton ❒ synthetic ❒ other *Comforter:* ❒ cotton ❒ Down ❒ other

Pets:

❒ cat ❒ dog ❒ bird ❒ other *Frequent contact:* ❒ in house ❒ access to bedroom

Infestation:

❒ cockroach ❒ mouse ❒ rat

Smoking:

❒ patient ❒ family member ❒ work ❒ other

Recreational Drug Use: ❒ yes ❒ no
Specify:________________________________

Work Environment:

Occupation:
❒ office ❒ factory ❒ outdoor ❒ other *Exposure:* smoke ❒ fumes ❒ chemicals ❒ other

Medical History:

❒ Emergency room visit or hospital stays in last 12 months. Specify ________________________________
❒ Currently on allergy shots
❒ Previous reaction to allergy shots. Specify ____

Past Medical/Past Surgical History:____

Current Meds (prescribed and over the counter): ____

(You may use the back of form if additional space is needed.)

CONTINUE ⟶

Patient Name: ____ **Date:** ____________

Past Medical History:

Disease	Patient	Father	Mother	Sibling
Asthma				
Hay Fever				
Eczema				
Hives				
Food Allergy				
Drug Allergy				
Frequent/Many Infections				
Sinus Infections				
Ear Infections				
Bronchitis				
Pneumonia				
Migraine				
Other Significant:				

Drug Reactions:

Date / Drug	Symptoms	Last taken
Latex		

Food Reactions:

Date/Food	Symptoms	Can eat now?
Bee		

List past allergy medications, duration,effect and reason for stopping:

____

____

____

Immunizations:

Childhood immunizations completed: ❐ Yes ❐ No

Last Flu shot ____________________________________ Last Pneumovax ______________________

Reaction to immunizations: ❐ Yes, specify ____ ❐ No

Questionnaire completed by: ____ (Printed Name)

Signature: ____