Allergy & ENT Associates

Specialized Care for Allergy, Asthma and Sinus Disease

New Patient Questionnaire P. 1

Location: ______________________

Patient Name ______________________ Date of Birth ______________________ Today's date ______________________

Referring Physician ______________________ Accompanied Today By ______________________

Other Family Members Who Are AAA Patients ______________________

In the boxes below - please mark all that apply.

Reason(s) for Visit

- ☐ hay fever/nasal allergies
- ☐ rash/skin allergies
- ☐ food allergy
- ☐ insect allergy
- ☐ eye problems
- ☐ headache/sinus problems
- ☐ ear problems
- ☐ sore throat
- ☐ cough
- ☐ shortness of breath/asthma
- ☐ chest infections
- ☐ Other: ______________________

First time problems occurred? ______________________ (date)

When did this specific episode start? ☐ 1 week ago ☐ 2 weeks ago ☐ 3 weeks ago ☐ 4 weeks ago ☐ more than a month ago ☐ unknown

How often does this problem occur? ☐ everyday ☐ once per week ☐ 2 x per week ☐ monthly ☐ several times a year ☐ unpredictable

Which month(s) is it most severe? ☐ Jan ☐ Feb ☐ March ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec ☐ All year

What time of day are the symptoms worse? ☐ morning ☐ noon ☐ afternoon ☐ nighttime ☐ all the time

Are symptoms worse in certain locations? ☐ home ☐ work ☐ outside ☐ indoors ☐ other: ______________________

Suspected cause of problems? ☐ trees ☐ weeds ☐ grass ☐ mold ☐ dust ☐ perfumes ☐ scents ☐ latex ☐ weather changes ☐ heat ☐ cold ☐ cats ☐ dogs ☐ stress ☐ smoke ☐ other (animals, foods, etc.): ______________________

How would you grade the degree of your symptoms in the last 4 weeks? ☐ none ☐ mild ☐ moderate ☐ severe

How would you grade your degree of symptoms today? ☐ none ☐ mild ☐ moderate ☐ severe

How long have you lived in the area? __________ ☐ days ☐ week(s) ☐ year(s)

Moved from where? ______________________

Where did you grow up? ______________________

Patient Name ____________ Date of Birth ____________ Today's date ____________

Review of Symptoms I

Please grade each of the following symptoms. (Mark all that apply)

Allergy/Sinus Symptoms	None	Mild	Moderate	Severe
Dark circles under eyes:	☐	☐	☐	☐
Itchy/watery eyes:	☐	☐	☐	☐
Red eyes:	☐	☐	☐	☐
Swollen/puffy eyelids	☐	☐	☐	☐
Ear infections:	☐	☐	☐	☐
Ear pain/pressure:	☐	☐	☐	☐
Ear popping:	☐	☐	☐	☐
Congestion/blocked nose:	☐	☐	☐	☐
Decreased sense of smell:	☐	☐	☐	☐
Nasal/sinus drainage:	☐	☐	☐	☐
Nose bleeds:	☐	☐	☐	☐
Runny nose:	☐	☐	☐	☐
Sinus infection:	☐	☐	☐	☐
Sinus pressure/pain:	☐	☐	☐	☐
Sneezing:	☐	☐	☐	☐
Snoring:	☐	☐	☐	☐
Snorting:	☐	☐	☐	☐
Sore throat:	☐	☐	☐	☐
Hoarseness:	☐	☐	☐	☐
Post nasal/throat drainage:	☐	☐	☐	☐
Throat clearing:	☐	☐	☐	☐

Neurological Symptoms	None	Mild	Moderate	Severe
Dizziness:	☐	☐	☐	☐
Fatigue/tired:	☐	☐	☐	☐
Headache:	☐	☐	☐	☐
Lightheadedness:	☐	☐	☐	☐
Problems sleeping:	☐	☐	☐	☐
Poor concentration:	☐	☐	☐	☐
Sleep apnea:	☐	☐	☐	☐

Asthma Symptoms	None	Mild	Moderate	Severe
Croup/laryngitis:	☐	☐	☐	☐
Chest infections:	☐	☐	☐	☐
Chest tightness:	☐	☐	☐	☐
Cough:	☐	☐	☐	☐
Cough productive of mucus:	☐	☐	☐	☐
Congestion:	☐	☐	☐	☐
Shortness of breath (SOB):	☐	☐	☐	☐
SOB with exercise:	☐	☐	☐	☐
SOB at night:	☐	☐	☐	☐
Wheezing:	☐	☐	☐	☐

Patient Name Date of Birth Today's date

Review of Symptoms I - Continued

Please grade each of the following symptoms. (Mark all that apply)

Skin Symptoms		None	Mild	Moderate	Severe
	Dry skin:	☐	☐	☐	☐
	Eczema:	☐	☐	☐	☐
	Hives:	☐	☐	☐	☐
	Itchy skin:	☐	☐	☐	☐
	Rash:	☐	☐	☐	☐
	Skin swelling:	☐	☐	☐	☐

Gastrointestinal Symptoms		None	Mild	Moderate	Severe
	Constipation:	☐	☐	☐	☐
	Diarrhea:	☐	☐	☐	☐
	Heartburn/Indigestion/Reflux:	☐	☐	☐	☐
	Nausea:	☐	☐	☐	☐
	Vomiting:	☐	☐	☐	☐

Other:	

Review of Symptoms II

(Mark all that apply)

General:	☐ fever ☐ chills ☐ night sweats ☐ weight loss ☐ weight gain
Ears:	☐ drainage ☐ hearing loss ☐ rupture of eardrum
Eyes:	☐ burning ☐ dry
Mouth:	☐ bad breath ☐ gum problems ☐ lip swelling ☐ tongue swelling ☐ pain in teeth ☐ teeth grinding ☐ mouth itching ☐ mouth ulcers
Throat:	☐ difficulty swallowing ☐ swelling ☐ loss of voice
Chest:	☐ chest pain ☐ heaviness/pressure ☐ heart palpitations
Urinary:	☐ excessive urination ☐ excessive thirst ☐ pain/burning with urination ☐ difficulty with urination
Extremities:	☐ swollen joints ☐ painful joints ☐ athletes foot/nail fungus
Neurological:	☐ anxiety ☐ stress ☐ depression ☐ numbness/tingling ☐ tremors ☐ developmental/growth delay ☐ heat or cold intolerance
Other:	

New Patient Questionnaire - Page 4

Patient Name ____ Date of Birth ____ Today's date ____

Asthma History A.

Have you had breathing problems or asthma symptoms including coughing, wheezing, or shortness of breath over the past 2-4 weeks? ☐ Yes ☐ No

Number of Daytime Symptoms: ________ Frequency ☐ Daily ☐ Weekly ☐ Monthly

Number of Night Time Symptoms: ________ Frequency ☐ Daily ☐ Weekly ☐ Monthly

Have you been previously diagnosed with asthma? ☐ Yes ☐ No

If "No" previous diagnosis of Asthma, proceed to Section B

What was your age when your asthma began? ____________________ ☐ years ☐ months

During a typical week (in the past 12 months) how often did you use a Beta Agonist inhaler (like Proventil, Albuterol or Ventolin) for asthma?

☐ less than once/week ☐ once or twice/week ☐ 3 x or more/week

☐ daily ☐ more than once daily ☐ never

During a typical week, how often were your activities limited by asthma symptoms such cough, wheezing, or shortness of breath?

☐ less than once/week ☐ once/week ☐ 1 x or more/week ☐ daily ☐ never

During the past 12 months, how many times have you gone to the emergency room or had an urgent doctor's visit because of asthma?

☐ none ☐ 1 x ☐ 2 x ☐ 3 x or more

Have you been admitted overnight to a hospital for asthma or breathing disorder in the last 12 months? ☐ Yes ☐ No

Do you get chest tightness, wheezing or shortness of breath within the first 15 minutes of exercise? ☐ Yes ☐ No

Do you check peak flows? ☐ Yes ☐ No

Best peak flow value ____________________

Do you have a written Asthma Action Plan? ☐ Yes ☐ No

Please complete entire section.

Asthma History B.

Did you ever have recurrent bronchitis, croup, asthma, reactive airway disease during childhood? ☐ Yes ☐ No

Have you had sudden severe episodes or coughing, wheezing or shortness of breath? ☐ Yes ☐ No

Have you had colds that go "to the chest" and take more than 10 days to get over? ☐ Yes ☐ No

Have you had coughing, wheezing, or shortness of breath in certain places when exposed to certain things (e.g. animals, tobacco, smoke, perfumes, etc.)? ☐ Yes ☐ No

Have you used medicine to help breathing? ☐ Yes ☐ No

If yes, do symptoms get better with medicine? ☐ Yes ☐ No

Do you get coughing, wheezing, or shortness of breath…

- at night? ☐ Yes ☐ No
- in the morning? ☐ Yes ☐ No
- with exercise? ☐ Yes ☐ No

Other:

Sinus History

Do you have sinus problems? ☐ Yes ☐ No

If No - Go to Allergy History Section

How many times have you been treated for a sinus infection with an antibiotic in the past year?

☐ none ☐ 1 x ☐ 2 x ☐ 3 x or more

Which antibiotic helped the most?

What is the color of your nasal drainage? (Mark all that apply)

☐ clear ☐ brown ☐ white ☐ green ☐ yellow ☐ blood - tinged

Have you ever had nasal polyps? ☐ Yes ☐ No

Have you ever had an x-ray or CT scan of your sinuses? ☐ Yes ☐ No

Performed When? ______________ Performed Where? ____________________________

New Patient Questionnaire - Page 5

Patient Name | Date of Birth | Today's date

Sinus History Continued

Have you ever had sinus surgery? ☐ Yes ☐ No

When was the sinus surgery? ____________

What type of surgery was it? ☐ caldwell luc ☐ ethmoidectomy ☐ graft ☐ rhinoplasty ☐ septoplasty ☐ turbinectomy ☐ other:____________

Who was the surgeon? ____________

Did the surgery help? ☐ Yes ☐ No ☐ Somewhat

Do the sinus problems disturb your sleep enough to cause fatigue, tiredness or sleepiness during the day? ☐ Yes ☐ No

General Other:

Allergy History

Do you experience the following:

hay fever/nasal allergies ☐ Yes ☐ No

age when allergies/hay fever began? ________ ☐ not sure

food allergy/intolerance ☐ Yes ☐ No

Please list details of food allergies below

Foods:	Date of Onset:	Reaction:

latex allergy ☐ Yes ☐ No

Please list details of latex allergies below

Product	Date of Onset:	Reaction:

insect reaction ☐ Yes ☐ No

Please list details of insect allergies below (Mark all that apply)

Insect:	Date of Onset:	Reaction:
☐ fire ant		
☐ honey bee		
☐ mosquito		
☐ wasp		
☐ white faced hornet		
☐ yellow hornet		
☐ yellow jacket		
☐ not sure		

Have you ever been tested for allergies? ☐ Yes ☐ No

How was testing performed? ☐ skin ☐ blood (rast)

How long ago was the test? ☐ less than 1 year ☐ 1 - 3 years ☐ 4 + years ☐ don't remember

What were you allergic to? (Mark all that apply) ☐ trees ☐ weeds ☐ grasses ☐ mold ☐ dust mites ☐ cats ☐ dogs ☐ foods ☐ insects ☐ latex

Did you get allergy shots? ☐ Yes ☐ No

How long did you take the shots? ☐ Years ☐ Months ☐ Weeks

If yes, were the shots helpful? ☐ Yes ☐ No

Who was your doctor? ____________

Where can we obtain your test results? ____________

Have you ever been prescribed an epipen (adrenalin/epinephrine)? ☐ Yes ☐ No

If yes, for what purpose? ____________

Other:

New Patient Questionnaire - Page 6

Patient Name ____ Date of Birth ____ Today's date ____

General History

Question		
In the last 6 months, have you had a cough longer than 6 weeks in a row?	☐ Yes	☐ No
In the last 6 months, have you had hoarseness for greater than 6 weeks?	☐ Yes	☐ No
In the last 6 months, have you coughed up any blood or bloody sputum?	☐ Yes	☐ No
Have you had a chest x-ray in the last year?	☐ Yes	☐ No

If yes, where was it performed? ____ When? ____

What were the results? ____

Question		
Have you had the pneumonia vaccine shot (pneumovax)?	☐ Yes	☐ No

If yes, when? ____

Question		
Do you normally get a flu shot every year?	☐ Yes	☐ No
Are your immunizations up to date?	☐ Yes	☐ No

During the last year, how many times have you had to take oral or injected steroids for allergies or asthma?

☐ none ☐ 1 x ☐ 2 x ☐ 3 x or more

During the last year, how many days have you missed school or work because of your allergies or asthma?

☐ none ☐ 1 day ☐ 2 days ☐ 3 x or more

During the last year, how many days have your allergies or asthma symptoms changed your productivity at work/school?

☐ none ☐ 1 day ☐ 2 days ☐ 3 x or more

How many times have you gone to the emergency room because of your allergies or asthma?

☐ none ☐ 1 x ☐ 2 x ☐ 3 x or more

How many times have you had to stay overnight at the hospital because of allergies or asthma?

☐ none ☐ 1 x ☐ 2 x ☐ 3 x or more

Are you pregnant? ☐ Yes ☐ No ☐ N/A

Date of last menstrual period? ____

Other Comments:

Social History

Occupation: ☐ n/a ☐ student ☐ hourly wage ☐ commission ☐ salary ☐ retired

Type of work: ____

Hobbies:

Tobacco use/ exposure?	☐ Current everyday smoker ☐ Smoker, current status unknown ☐ Former smoker ☐ Current someday (social) smoker ☐ Never smoked ☐ Unknown if ever smoked
If Current or Former Smoker:	**Type:** ☐ **Chewing** ☐ **Cigars** ☐ **Cigarettes** ☐ **Pipe** ☐ **Smokeless** ☐ **Snuff** Packs/Units per Day ____ Years Used ____ Ever tried to quit? Y N Year Quit ____

Passive/Second hand smoke exposure? ☐ Yes ☐ No Who/Where: ____

Question			
Do you drink alcohol?	☐ Yes	☐ No	
Recreational drug use?	☐ Yes	☐ No	
Do you have any HIV risk factors?	☐ Yes	☐ No	☐ Not sure

New Patient Questionnaire - Page 7

Patient Name | Date of Birth | Today's date

Environmental History

(Mark all that apply)

Do you have any pets? ☐ Yes ☐ No

Type of pets?
- ☐ cats how many # ______
- ☐ dogs how many # ______
- ☐ other how many # ______

Are they……..? ☐ inside ☐ outside ☐ both

Do they sleep in the bedroom? ☐ Yes ☐ No

How old is your home/apartment? ______ years

What type of flooring is in your home? ☐ carpet ☐ linoleum ☐ tile ☐ hardwood ☐ rugs ☐ other

What window coverings are in your home?

☐ none ☐ cloth ☐ drapes ☐ wood shutters ☐ plastic/metal blinds ☐ other

Do you use any type of fans in your home? ☐ Yes ☐ No

Do you use a fan in your bedroom? ☐ Yes ☐ No

What type of heating/cooling system do you have? ☐ window units ☐ space heaters ☐ central air/heat ☐ other

What exposure do you have at school/work?

☐ mold ☐ animals ☐ chemical exposure ☐ paint fumes ☐ smoke ☐ other

Has there been any water leakage or water damage in your home? ☐ Yes ☐ No

Do you have visible mold or a musty odor in your home? ☐ Yes ☐ No

If patient is a child, does he/she attend daycare? ☐ Yes ☐ No ☐ N/A

Family History

Race?	☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ Caucasian/White ☐ Hispanic ☐ More than one race ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown/Not Reported
Ethnicity?	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Not Reported
Preferred Language?	

Are there any family disputes/divorce situations that may make patient care more difficult? ☐ Yes ☐ No

(Mark any family members who have experienced any of the listed conditions)

	Father	**Mother**	**Brothers**	**Sister**	**Son**	**Daughter**
Allergies:	☐	☐	☐	☐	☐	☐
Sinus:	☐	☐	☐	☐	☐	☐
Asthma:	☐	☐	☐	☐	☐	☐
Eczema:	☐	☐	☐	☐	☐	☐
Hay fever:	☐	☐	☐	☐	☐	☐
Hives:	☐	☐	☐	☐	☐	☐
Migraine:	☐	☐	☐	☐	☐	☐
Thyroid Disease:	☐	☐	☐	☐	☐	☐
Emphysema:	☐	☐	☐	☐	☐	☐
Cystic Fibrosis:	☐	☐	☐	☐	☐	☐
Tuberculosis:	☐	☐	☐	☐	☐	☐
Other:						

New Patient Questionnaire - Page 8

Patient Name | Date of Birth | Today's date

Medical History

Please mark all that describe your current or past medical problems.

☐ high blood pressure	☐ reflux	☐ thyroid problems
☐ heart attack	☐ hiatal hernia	☐ kidney problems
☐ stroke	☐ diabetes	☐ chronic infections
☐ glaucoma	☐ emphysema	☐ skin problems
☐ cataracts	☐ lupus/other autoimmune disease	☐ liver problems
☐ depression		☐ bleeding problems
☐ bipolar	☐ gout	☐ osteoporosis/osteopenia
☐ ADD/ADHD	☐ arthritis	
	☐ fibromyalgia	

Please list all previous hospitalizations/surgeries/prosthetics devices (artificial limbs).

Description	Year

Other:

Pharmacy Information

Pharmacy Name:

Pharmacy Address:

Street

City | State | Zip

Pharmacy Phone #:

Pharmacy Fax #:

Prescription Type: ☐ **90 day mail in** ☐ **Local** ☐ **Mail & Local**

Patient Name | Date of Birth | Today's date

Medication History

Please list your prescription, non - prescription, herbal drugs, creams, sprays, pills, liquids, or drops.

Current Medications

Medication name	Dose	Frequency

Medication Allergies

Do you have any known drug allergies or intolerance to medications? ☐ Yes ☐ No

Medication Allergies:

Medication name	Type of reaction	When/date

Other Notes:	