1st Health Center

Asthma • Allergy • Immunology

NEW PATIENT QUESTIONNAIRE

To be filled out by the patient or the parent/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 box to the best of your knowledge and as accurately as possible. **Please complete as time permits and present at next appointment.**

Patient's Name ________________________ DOB _____ /_____ /_____ Age__________

Today's Date ________________________

Previous Allergy/Immune Workup Date __________ Tests Performed ________________________

Allergy Shots ________________________ ☐ Past ☐ Present ☐ Previous reactions to allergy shots

Referring Physician ________________________

Describe Primary Complaint: ________________________

Specialists Involved In Care: ________________________

GENERAL

Weight: ☐ Normal ☐ Gain ☐ Loss

Energy: ☐ Normal ☐ High ☐ Low

☐ Feverish ☐ Chills ☐ Hair loss

SKIN

- ☐ Rash (suspected cause ____________________)
- ☐ Hives
- ☐ Eczema, boils, infections
- ☐ Dryness, itching
- ☐ Insect bite reaction

HEAD

- ☐ Migraine
- ☐ Headache (location ______________)
- ☐ Head injury (when ______________)

EYES

- ☐ Strain, change in vision
- ☐ Redness, puffiness, discharge
- ☐ Itching, rubbing
- ☐ Watery ☐ Red

EARS

- ☐ Pain, discharge
- ☐ Itch, popping
- ☐ Infections, hearing loss

GASTROINTESTINAL

- ☐ Abdominal pain ☐ Diarrhea
- ☐ Reflux ☐ Vomiting
- ☐ Nausea

NEUROLOGICAL

- ☐ Vertigo ☐ Tremors
- ☐ Confusion ☐ Memory loss
- ☐ Difficulty walking

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
  - ☐ At rest ☐ With activity
- ☐ Cough
  - ☐ Day ☐ Night ☐ Exercise
  - ☐ Dry ☐ Wet
- ☐ Chest tightness
- ☐ Shortness of breath

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Muscle pain

PSYCOLOGICAL

- ☐ Depressed
- ☐ Other: ________________________

Please check all that apply:

SYMPTOMS

Symptoms worsen: ☐ indoor ☐ outdoor ☐ home ☐ work ☐ morning ☐ afternoon ☐ night

Symptoms worsen in: ☐ 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 or crying ☐ medication (specify__________________)
☐ infection

LIVING ACCOMMODATIONS

Location: ☐ city ☐ suburb ☐ country/farm

Structure: ☐ house ☐ apartment
age of building ____________________ number of years at this address ______________________
recent painting or repairs ____

Basement: ☐ slab ☐ finished ☐ dry ☐ damp ☐ mildew

Flooring: ☐ hardwood ☐ carpet—(☐ wool ☐ synthetic)
☐ padding—(☐ rubber ☐ ozite ☐ other)

Furniture: ☐ new ☐ antique

Window Treatments: ☐ 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

Bedroom Windows Open: ☐ day ☐ night ☐ winter ☐ summer

Bedding: mattress cover: ☐ cotton pad ☐ allergy proof
box spring cover: ☐ cotton ☐ allergy proof
pillows: ☐ feather ☐ polyester ☐ kapok
comforter: ☐ cotton ☐ down ☐ other____

Pets: ☐ cat ☐ dog ☐ bird ☐ other ____
frequent contact: ☐ in house ☐ with access to bedroom

Infestation: ☐ cockroaches ☐ mice ☐ rats

Smoking: ☐ patient ☐ family member ☐ co-workers ☐ other ______________________________

WORK ENVIRONMENT

Occupation: ____
☐ office ☐ factory ☐ outdoor ☐ other ____
exposure to: ☐ smoke ☐ fumes ☐ chemicals ☐ other ______________________________

DRUG OR LATEX REACTIONS

Date	Drug	Symptoms	Date last taken

FOOD REACTIONS

Date	Food	Symptoms	Can eat now?

VENOM/INSECT REACTIONS

☐ Yes ☐ No Specify ____

HOSPITAL/EMERGENCY ROOM HISTORY Please list all hospitalizations, approximate year, reason and location.

Surgery	Date	Reason	Location

SURGICAL HISTORY Please list all surgeries, approximate year, reason and location.

Surgery	Date	Reason	Location

IMAGING HISTORY

☐ None Last chest X-ray ____/____/____ Last Sinus CT ____/____/____

IMMUNIZATIONS

Childhood immunizations completed: ☐ Yes ☐ No

Last flu shot ____/____/____ Last Pneumovax ____/____/____ Last Tetanus____/____/____

Reaction to immunizations: ☐ Yes ☐ No Specify ____

PAST MEDICAL HISTORY

Please indicate if you have ever been diagnosed with any of the conditions listed below, include the following information: (a) symptoms, (b) medications, (c) surgeries, (d) hospitalization, or (d) emergency room visits if required, and (f) specialists involved in care.

Immune Deficiencies: Specify: ______________________________

Malignancies: Specify: ______________________________

DIAGNOSIS	NO	YES	DESCRIPTION OF TREATMENT
Autoimmune Disorders:			
Systemic Lupus Erythematosus	☐	☐	______________________
Sjogren's Syndrome	☐	☐	______________________
Scleroderma	☐	☐	______________________
Rheumatoid Arthritis	☐	☐	______________________
Diabetes Mellitus	☐	☐	______________________
Thyroid Disorder	☐	☐	______________________
Musculoskeletal:			
Fibromyalgia	☐	☐	______________________
Gastrointestinal:			
Crohn's Disease	☐	☐	______________________
Ulcerative Colitis	☐	☐	______________________
Irritable Bowel Syndrome	☐	☐	______________________
Gastroesophageal Reflux Disease	☐	☐	______________________
Neurological:			
Multiple Sclerosis	☐	☐	______________________
CIDP	☐	☐	______________________
ALS	☐	☐	______________________
Seizure Disorder	☐	☐	______________________
ADHD	☐	☐	______________________
Mental Health:			
Bipolar	☐	☐	______________________
Depression	☐	☐	______________________
Anxiety	☐	☐	______________________

PAST MEDICAL HISTORY
continued

DIAGNOSIS	NO	YES	DESCRIPTION OF TREATMENT
Developmental:			
Development Delay	☐	☐	________________
Down Syndrome	☐	☐	________________
Autism	☐	☐	________________
Failure to Thrive	☐	☐	________________
Cardiac Disorders:			
Coronary Artery Disease	☐	☐	________________
Chronic Heart Failure	☐	☐	________________
Hypertension	☐	☐	________________
Pleurisy	☐	☐	________________
Arrhythmia	☐	☐	________________
Pulmonary Disorders:			
Chronic Obstrictove Pulmonary Disease	☐	☐	________________
Chronic Bronchitis	☐	☐	________________
Asthma	☐	☐	________________
Pulmonary Embolism	☐	☐	________________
Pneumothorax	☐	☐	________________
Skin Disorders:			
Psoriasis	☐	☐	________________
Atopic Dermatitis	☐	☐	________________
Urticaria “hives”	☐	☐	________________
Pemphigus	☐	☐	________________
Obstetrical Disorders:			
Recurrent Miscarriage	☐	☐	________________

Family History:

Has anyone in your family been diagnosed with any of the conditions listed above? ☐ Yes ☐ No

Please specify: ____

____

____

____

____

____

INFECTION HISTORY

Have you experienced frequent infections in the past few years? If no, please disregard the following section and proceed to the next section.

Serious Bacterial Infections:

Please indicate if you have experienced any serious bacterial infections listed below, include the following information: (a) type of infection, (b) numbers, (c) approximate dates and frequency, (d) antibiotics, steroids or other medications, (e) surgeries, (f) hospitalization, or (g) emergency room visits if required, and (h) specialists involved in care.

TYPE OF INFECTION	NO	YES	DESCRIPTION OF TREATMENT
Meningitis	☐	☐	________________
Sepsis/Bacteremia	☐	☐	________________
Osteomyelitis	☐	☐	________________
Septic Arthritis	☐	☐	________________
Visceral Abscess	☐	☐	________________
Pheumonia	☐	☐	________________

Infection Treatments:

1) Please estimate the number of antibiotics required in the past year? ________________
2) Have you had infections that persist despite antibiotic therapy? If yes, what type and what treatments were attempted?
   ____
3) Have you ever required an antibiotics course for longer than two weeks? Or for maintenance therapy? If yes, please describe:
   ____
4) Have you ever required IV antibiotics to clear an infection? If yes, please describe: ________________
   ____
5) Have you ever required surgery due to persistent infection? If yes, please describe: ________________
   ____

Bacterial Infections

Please indicate if you have experienced frequent bacterial infections in the past few years listed below, include the following information: (a) type of infection, (b) numbers, (c) approximate dates and frequency, (d) antibiotics, steroids or other medications, (e) surgeries, (f) hospitalization, or (g) emergency room visits if required, and (h) specialists involved in care.

TYPE OF INFECTION	NO	YES	DESCRIPTION OF TREATMENT
Skin:			
Cellulitis	☐	☐	______________________
Impetigo	☐	☐	______________________
Abscess	☐	☐	______________________
Eye:			
Conjunctivitis	☐	☐	______________________
Ear:			
Otitis Media	☐	☐	______________________
Otitis Externa	☐	☐	______________________
Sinus:			
Sinusitis	☐	☐	______________________
Mouth:			
Tooth Abscess	☐	☐	______________________
Throat:			
Strep Pharyngitis	☐	☐	______________________
Respiratory:			
Pneumonia	☐	☐	______________________
Bronchitis	☐	☐	______________________
Heart:			
Endocarditis	☐	☐	______________________
Pericarditis	☐	☐	______________________
Gastrointestinal:			
E. Coli	☐	☐	______________________
Campylobacter	☐	☐	______________________
Giardia	☐	☐	______________________
Urinary:			
Urinary Tract Infections	☐	☐	______________________
Pyelonephritis	☐	☐	______________________
Other, Specify	☐	☐	______________________

Viral Infections

Please indicate if you have experienced frequent viral infection listed below, include the following information: (a) frequency of infections, (b) antiviral medications, steroids, or other medications, (c) surgeries, (d) hospitalization, or (e) emergency room visits if required, and (f) specialists involved in care.

TYPE OF INFECTION	NO	YES	DESCRIPTION OF TREATMENT
Respiratory:			
Upper Respiratory Infections	☐	☐	___
Croup	☐	☐	___
Bronchiolitis	☐	☐	___
Influenza	☐	☐	___
Gastrointestinal:			
Viral Gastroenteritis	☐	☐	___
Rotavirus	☐	☐	___
Systemic:			
EBV “mono”	☐	☐	___
Cytomegalovirus	☐	☐	___
Parvovirus	☐	☐	___
Herpes Simplex	☐	☐	___
Chicken Pox	☐	☐	___
Shingles	☐	☐	___
Fungal Infections:			
Ringworm	☐	☐	___
Thrush	☐	☐	___

QUALITY OF LIFE

Are you able to work or attend school? If not, please describe why ______________________________

Is your attendance poor? If yes, please describe why ______________________________

Are you able to carry out normal daily activies? If not, please describe why ______________________________

What is your activity level? ______________________________

Do you have ambulation deficits? ☐ Yes ☐ No Specify ______________________________

What condition or symptom(s) most affect your quality of life? Please specify.

SYMPTOM/ CONDITION	NOT AT ALL	SOMEWHAT	VERY MUCH
Asthma	☐	☐	☐
Allergies			
Nasal symptoms	☐	☐	☐
Eye symptoms	☐	☐	☐
Food related symptoms	☐	☐	☐
Eczema	☐	☐	☐
Recurrent infection	☐	☐	☐

Other: ______________________________

What types of activities are affected?

	NOT AT ALL	SOMEWHAT	VERY MUCH
Occupational/ Academic			
Attendance	☐	☐	☐
Functional Capacity	☐	☐	☐
Leisure	☐	☐	☐
Sleep	☐	☐	☐
Exercise Capacity			
Light Activity (i.e. Walking)	☐	☐	☐
Moderate Activity (i.e. Golfing)	☐	☐	☐
Vigorous Activity (i.e. Running)	☐	☐	☐
Activities of daily living			
Dressing self	☐	☐	☐

Other: ______________________________

Do your symptoms affect your:

	NOT AT ALL	SOMEWHAT	VERY MUCH
Mood	☐	☐	☐
Energy level	☐	☐	☐

In general do you feel your health is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Compared to one year ago, how would you rate your health now?

☐ Much better ☐ Somewhat better ☐ The same ☐ Somewhat worse ☐ Much worse

Questionnaire completed by (printed name): ______________________________

Relationship to patient: ______________________________

Signature: ______________________________