

Allergy & Asthma Associates - Established Patient Questionnaire

Patient Name	Date of Birth	Today's date
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<i>Reason for Visit:</i>	
<input type="checkbox"/> Allergy Test	<input type="checkbox"/> Routine Follow up
<input type="checkbox"/> Immunotherapy Re-evaluation	<input type="checkbox"/> Sick/ill Visit <input type="checkbox"/> Other _____

<i>Chief Complaint:</i>	
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Cough <input type="checkbox"/> Asthma/Breathing problem
<input type="checkbox"/> Rash/Skin problems	<input type="checkbox"/> Allergies
<input type="checkbox"/> Other _____	

<i>Since your last visit</i>	
Have you been satisfied with your health?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have your medications caused any problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what problems did they cause? (Mark all that apply)	
<input type="checkbox"/> sleeplessness	<input type="checkbox"/> drowsiness <input type="checkbox"/> nervousness <input type="checkbox"/> headache
<input type="checkbox"/> shakiness	<input type="checkbox"/> sore throat <input type="checkbox"/> cough
<input type="checkbox"/> other _____	
Are you taking allergy shots?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, have you had any problems with your shots?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what problems have you had? (Mark all that apply)	
<input type="checkbox"/> large local reactions	<input type="checkbox"/> pain <input type="checkbox"/> rash <input type="checkbox"/> breathing problems
<input type="checkbox"/> other _____	
Has your family or medical history changed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list any changes: _____	
Has your social history changed? (occupation, alcohol, drug use etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list any changes: _____	
<u>Tobacco use/ exposure?</u>	<input type="checkbox"/> Current everyday smoker <input type="checkbox"/> Smoker, current status unknown <input type="checkbox"/> Former smoker
	<input type="checkbox"/> Current someday (social) smoker <input type="checkbox"/> Never smoked <input type="checkbox"/> Unknown if ever smoked
If Current or Former Smoker:	Type: <input type="checkbox"/> Chewing <input type="checkbox"/> Cigars <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Snuff
	Packs/Units per Day _____ Years Used _____
	Ever tried to quit? Y N Year Quit _____
Passive/Second hand smoke exposure?	<input type="checkbox"/> Yes <input type="checkbox"/> No Who/Where: _____
Have there been any significant changes in your home or work environment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list any changes: _____	
If you have already had allergy testing, have you made changes in your home or behavior as suggested for controlling the allergens to which you are exposed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list any changes: _____	
Have you had breathing problems or asthma symptoms including coughing, wheezing, or shortness of breath over the past 2-4 weeks (not just with acute attacks)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of Daytime Symptoms: _____	Frequency <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Number of Night Time Symptoms: _____	Frequency <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Since your last visit has your asthma been....	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change
Has your asthma or breathing problem caused you to miss work, school, or change your activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any emergency room visits or hospital stays?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems you wish to discuss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list the problems to discuss: _____	

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Current Medications

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

Medication Name	Dose	Frequency

Medication Allergies

Do you have any drug allergies or intolerance to medications?

Yes No

Medication Name	Type of Reaction	When/Date

Nasal Rinse

Are you using a nasal saline rinse

Yes No

IT Frequency

If you are taking allergy shots - how often do you receive the shots?

once a wk twice a wk every 2 wks every 3 wks every 4 wks every 6 wks

Other Notes:

Current Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Street

City

State

Zip

Pharmacy Phone #: _____

Pharmacy Fax #: _____

Prescription Type:

90 day mail in

Local

Mail & Local

Allergy & Asthma Associates
Established Patient Questionnaire Review of Systems

Date: _____ Patient Name _____ Date of Birth _____

Are you experiencing any of the following symptoms? Please answer/check NO or YES to EACH.

General	NO	YES		Respiratory	NO	YES		Urinary	NO	YES		Psychiatric	NO	YES
Chills				Chronic cough				Dribbling				Anxiety		
Fatigue				Cough				Pain on urination (dysuria)				Depression		
Fever				Known exposure to TB				Blood in urine (hematuria)				Insomnia/Sleep problems		
Malaise				Shortness of breath				Large amt of urine (polyuria)						
Night sweats				Wheezing				Slow stream				Skin	NO	YES
Weight gain				*Cough productive of mucus				Urinary frequency				Contact allergy		
Weight loss				*Chest tightness				Urinary incontinence				Hives		
								Urinary retention				Itching		
Ear/Eye/Nose Throat	NO	YES		Cardiovascular	NO	YES		*Urinary urgency				Mole changes		
Ear drainage				Chest pain				Metabolic/Endocrine	NO	YES		Rash		
Ear pain				Leg pain with exercise (claudication)				Brittle hair				Skin lesion		
Eye discharge				Edema				Brittle nails				*Eczema		
Eye pain				Palpitations				Cold intolerance						
Hearing loss				*Shortness of breath with exertion				Hair changes				Musculoskeletal	NO	YES
Nasal drainage				*Ankle swelling				Heat intolerance				Back pain		
Sinus pressure								Excess hair growth (Hirsutism)				Joint pain		
Sore throat				Gastrointestinal	NO	YES		Excessive thirst (polydipsia)				Joint swelling		
Visual changes				Abdominal pain				Increased appetite (polyphagia)				Muscle weakness		
*Ear pressure				Blood in stools								Neck pain		
*Ear popping				Change in stools				Neurological	NO	YES				
*Itchy eyes				Constipation				Dizziness				Blood/Lymph	NO	YES
*Watery eyes				Diarrhea				Extremity numbness				Easy bleeding		
*Red eyes				Heartburn				Extremity weakness				Easy bruising		
*Congestion/blocked nose				Loss of appetite				Walking/Gait disturbance				Swollen lymph nodes		
*Nose bleeds				Nausea				Headache						
*Sneezing				Vomiting				Memory loss				Immunologic	NO	YES
*Pain with swallowing								Seizures				Environmental allergies		
*Post nasal/throat drainage								Tremors				Food allergies		
												Seasonal allergies		