LAKE ALLERGY,
ASTHMA & IMMUNOLOGY

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NEW PATIENT QUESTIONNAIRE: ADULTS

INSTRUCTIONS: Carefully complete all 3 pages of this form in full. Relate all answers to your own experience.

NAME: _____ AGE: _____ DOB: _____ DATE: _____

Referred by: _____ Your primary physician is: _____
Address (if not local): _____

Circle the allergy problem(s) that you have:

Runny / stuffy nose (hay fever)	Sinusitis	Insect allergy	Eye or ear problems
Asthma	Eczema / rash	Drug allergy	Headache
Cough	Hives or swelling	Food allergy	Frequent infections

The major problem you wish to discuss is: _____

List **all** prescription and over the counter medications you are now using (name & dosage):

_____

_____

_____

List medications you have tried in the past for your allergy problems: _____

_____

Are you allergic to any medicines? List drug, type of reaction and year: _____

_____

I. Symptoms

Eyes:	Itch___	Swell___	Burn___	Tear___	Discharge___	Dry___
Ears:	Itch___	Fullness___	Popping___	⇓ hearing___	Pain___	Ringing___
Nose:	Sneeze___	Itch___	Runs___	Stuffy___	Mouth breather___	
	Snoring___	Headache ___	Decreased smell___		Decreased taste___	
Throat:	Itch___	Sore___	Post nasal drip___	Throat clearing___	Swelling___	
Chest:	Cough___	Phlegm___	Hoarseness___	Asthma diagnosed by a physician___		
	Wheezing___	Heartburn___	Chest Tightness___	Shortness of breath with exercise___		
Skin:	Eczema___	Hives___	Swelling___	Rashes__where on body?_____		

A. Respiratory allergies

1. Age of onset of your hay fever _____, and/or asthma _____
2. Do you have daily symptoms? _____
3. What time of year are your allergies or asthma worse? (please list months) _____
4. What time of day or night is the worst for your symptoms? _____
5. Does any particular exposure (e.g.cat, smoke, weather change, work, school) make you worse?(list)
   _____
6. Do you get sinus infections (yellow/green nasal drainage, pain, etc.)? _____How often? _____
   How is it usually treated? _____
7. Have you had nose or sinus surgery? _____

8. Have you been told by a physician that you have nasal polyps?_____
9. Have you ever been hospitalized for your asthma? _____ Emergency room?_____

B. Insect allergy

Have you had a severe allergic reaction to a stinging insect (bee, wasp, yellow jacket, hornet, fire ant)? (explain)_____

C. Food allergies

Please list all foods and reaction they cause: _____
_____

D. Have you had hives (welps) before? (when and for how long)_____

E. Have you had eczema (red, scaly, itchy skin) previously?_____

F. Are you sensitive to latex or rubber products? (explain) _____

II. Previous Allergy Evaluation and Treatment

A. Name of allergist and city_____

B. Were you tested for allergies by skin test or blood test? _____When _____ Results: _____
_____

C. Have you received allergy shots? _____When, how long: _____

D. Have you ever had steroid pills (dosepak, Prednisone) or shots (cortisone)? _____When _____

III. Past Medical History

A. Medical problems: (please circle)

Diabetes	Thyroid problem	High cholesterol	
Prostate Heart disease	Glaucoma	High blood pressure	
Abnormal chest x-ray	Stomach ulcer	Hiatal hernia	Depression
Positive Tb test	Arthritis	Hepatitis	GERD (acid reflux)
Cancer	HIV / AIDS	Other: _____	

B. Please list all important operations and other hospitalizations that you have had: _____
_____

C. Have you ever had a blood transfusion? _____

D. Have you had a chest x-ray, sinus x-ray, breathing test, blood tests? Comment on results. _____
_____

E. When was your last tetanus vaccination? (every 10 years) _____

F. Do you receive the flu vaccine yearly?
_____

G. Have you received the Pneumovax? (pneumonia vaccine) _____

IV. Family History

A. How many siblings do you have? ____ brothers, _____ sisters. How many children? _____ boys, _____ girls

B. Do these people or your parents have any of the allergy problems mentioned above? (list and comment)
_____

C. Are there any hereditary diseases or other disorders that seem to occur frequently in your family? _____
_____

V. Personal and Environmental History

A. Do you presently smoke? (how much and how long) _____

B. Have you ever smoked? (how much and how long) _____ Quit: ____ years ago

C. Are there smokers other than yourself at home? _____, how many _____

D. Do you have animals at home? (type and for how long) _____
E. Do you have mostly wall-to-wall carpeting in your home? _____In your bedroom? _____
F. What is your occupation? _____
- Are you exposed to any toxic chemicals, noxious substances at work? _____
- Has your problem caused you to miss work? _____
G. How much alcohol do you drink? _____
H. Do you use recreational drugs? (this is confidential) _____
I. How long have you lived in the area? _____ If not here year round, other home is in _____
J. How many other people live in your home? _____Are you: married / single / separated / divorced / widow
K. Do you have a standard mattress? _____ or waterbed? _____
L. Do your symptoms become better or worse on vacations or at the beach? _____
M. What are your daily activities, hobbies? _____

VI. Review of Systems: Do you have any of the following? (check)

General
____ weight loss
____ fever
____ night sweats
____ loss of appetite
____ dry mouth
____ snoring

Eyes and ears
____ dry eyes
____ change in vision
____ trouble hearing
____ ringing in ears

Skin
____ skin rashes

Endocrine
____ cold / heat intolerance
____ increased thirst
____ frequent urination

Gastrointestinal
____ nausea / vomiting
____ diarrhea
____ change in bowel habits
____ trouble swallowing
____ heartburn

Cardiovascular
____ chest pain
____ chest pain with exercise
____ calf pain with exercise
____ ankle swelling

Neurological
____ weakness / clumsiness
____ tingling/numbness of extremities

Psychological
____ fearful, anxious
____ excessive worry
____ trouble sleeping

Kidney
____ trouble starting urine
____ loss of urine with cough / sneeze
____ frequent nighttime urination

Blood
____ anemia (low blood)
____ bleed or bruise easily
____ swollen lymph nodes

Musculoskeletal
____ morning joint stiffness and aching
____ painful, swollen joints
____ muscle tenderness or pain
____ muscle weakness
____ abnormal bone density

Gynecological
____ excess bleeding
____ changes in menstrual cycle
____ post-menopausal

VII. Additional Information
Anything else you want to discuss during your initial visit?
_____
_____
_____
_____
_____