

THE ALLERGY AND ASTHMA CLINIC

ANDREW C. ENGLER, M.D.
BROOKE LEON, N.P.

JUNE Y. ZHANG, M.D.
ELISABETH DENKER, N.P.

****Please plan on spending at least 2 hours at this first visit.***

Date: _____

Dear _____,

We are looking forward to seeing you on: _____.

I am enclosing some information about our medical practice. I am also enclosing a medical questionnaire which we ask all our new patients to fill out. It is very important that you complete these forms prior to your appointment and bring them with you when you arrive. This information will help our specialists diagnose and formulate a treatment plan for your allergies.

In order to do allergy testing, we ask all our patients to please stop taking antihistamines for 3 to 7 days prior to their scheduled appointment.

Allergy testing can be an important tool in making a definitive diagnosis as to the cause of your allergies. If antihistamines are in your body's system, the test results may give us a false reading. If you have any questions about any of your medications, please give us a call and one of our nurses will be happy to assist you.

Free parking is available in the Mills Square parking garage. Please bring in your ticket so that we can validate it for you. If you choose, metered street parking is also available.

Please plan to arrive approximately 15 minutes early for your appointment to allow time for check-in and new patient processing.

Thank you for choosing The Allergy & Asthma Clinic. We will do our very best to help you with your allergies.

Sincerely,

Patient Services Representative

Please note our Cancellation Policy, as follows:

Notice of cancellation or re-scheduling is required no less than 2 business days prior to any scheduled appointment to allow us to give the appointment time to another patient. Cancellations, re-scheduling or "no-shows" with less than 2 business days' notice will be subject to a \$50.00 charge.

290 Baldwin Avenue San Mateo, CA 94401
Phone: (650)343-4597 Fax: (650)343-3402
www.theallergyclinic.com

Please do not take any antihistamines for at least three days prior to your appointment. If you have any questions about your medications, please call the office and we will be happy to help you.

NAME: _____ **DATE:** _____

What would you like to accomplish during your visit at the Allergy and Asthma Clinic?

• **SYMPTOM HISTORY:** Which of the following symptoms are you currently experiencing or have you experienced in the past?

NASAL/THROAT

- Mucous dripping down the back of your throat (post-nasal drip)
- Congestion or stuffiness
- Sneezing
- Itchy nose/Itchy throat
- Nosebleeds
- Runny nose - what color mucous comes out? _____

SINUSES

- Pain/Pressure
- Congestion
- Headache

EARS

- Itching
- Fullness
- Popping

CHEST

- Cough/Dry/Productive of: _____
- Chest tightness
- Shortness of breath
- Wheezing
- Cough with exercise
- Cough with laughter
- Coughing at night or when you lay down

EYES

- Watering/tearing
- Itching
- Redness
- Swelling

SKIN

- Itching
- Swelling
- Rashes
- Hives/Welts
- Dry skin

HEADACHES

- No
- Yes

Which of the above symptoms bother you the most?

FOR OFFICE USE ONLY

T: _____ P: _____ RR: _____ BP: _____ NURSE: _____

• **SYMPTOM HISTORY:**

My symptoms are worse during;

- spring
- summer
- fall
- winter

My symptoms are present all throughout the year but flare-up during the _____.

• **PROVOKING FACTORS:**

Do any of these things bring on or aggravate your symptoms?

- Trees/Pollens
- Dust/Molds
- Dog/Cat/Other animals
- Tobacco smoke
- Weather changes
- Cold air/Air conditioning
- Chemicals/Perfumes
- Exercise or Physical exertion
- Laughter
- Foods? Which ones? _____

What symptoms are associated with these foods? _____

• **ALLERGY HISTORY:**

Have you been treated for allergies in the past? YES NO

Did you see an allergist? YES NO Which doctor? _____

What kind of testing was done? _____ What city? _____

- Skin testing
- Blood testing (RAST)

When was testing done? _____

What were the results? _____

What type of treatment was recommended? _____

If you were placed on allergy shots, how long were you on them? _____

Did they help with your allergies? YES NO

Did you have any significant reactions to your allergy shots? YES NO

If yes, please explain: _____

MEDICATION HISTORY:

Please list **prescription allergy** medications you are currently taking. Please include all pills, eye drops, nasal sprays and lung sprays.

MEDICATION	DOSE	HOW OFTEN	DOES IT HELP?	SIDE EFFECTS

Please list **over-the-counter allergy** medications (non-prescription) you are currently taking.

MEDICATION	DOSE	HOW OFTEN	DOES IT HELP?	SIDE EFFECTS
------------	------	-----------	---------------	--------------

Have you ever taken any of the following antihistamines?

	YES	NO	DID IT HELP ?	SIDE EFFECTS
1. Allegra 30 mg/60 mg/180 mg	_____	_____	_____	_____
2. Claritin/loratadine 10 mg	_____	_____	_____	_____
3. Zyrtec 5 mg/10 mg	_____	_____	_____	_____

Please list other medications you have taken in the past (those not listed above) for your allergy and asthma.

• **GENERAL MEDICAL HISTORY:**

Who is your primary doctor or family physician? _____ City: _____

Please list the names of your other physicians? _____

Do we have your permission to fax records to your primary care or family doctor or referring provider? Yes No

Are you allergic to any medications?

No Yes; I am allergic to: _____

What type of reaction did you have? _____

PAST MEDICAL HISTORY:

Do you have or have you been treated for any of the following. Please check all that apply.

- High blood pressure Elevated cholesterol Gastroesophageal reflux (GERD) Diabetes
- Liver Disease/Hepatitis Sexually Transmitted Disease Glaucoma Shingles Other _____

Respiratory Diseases: Asthma Pneumonia Pertussis or Whooping Cough Tuberculosis Influenza

VACCINATIONS: Last flu shot: _____ I do not typically get a flu shot.

Tdap: Yes No Shingles: Yes No Pneumovax (pneumonia vaccination): Yes No Date: _____

What medications are you currently taking for your **other medical conditions**?

MEDICATION	DOSE	HOW OFTEN	FOR WHAT CONDITION
------------	------	-----------	--------------------

• **SMOKING HISTORY:**

- Cigarettes Marijuana
- I have never smoked.
- I stopped smoking _____ years ago. I used to smoke _____ pack(s) a day for _____ years.
- I am a smoker and smoke about _____ pack(s) per day.
- I do not smoke but I am frequently exposed to second hand smoke at _____.

• **ALCOHOL**

Social 1-2 times a week Other _____

• **EXERCISE**

No Rarely At least 2-3 times a week

• **SURGICAL HISTORY:**

I have not had any surgeries.

Yes, I have had;

Tonsils/Adenoids Date: _____

Nasal/Sinus surgery Date: _____ Surgeon: _____

Other: _____ Date: _____

Were there any complications associated with your surgery, including the anesthesia used?

No Yes; please explain. _____

• **IMAGING STUDIES (XRAYS):**

None

Sinuses Date: _____ Results: _____

Chest Date: _____ Results: _____

REVIEW OF SYSTEMS:

- | | | | |
|---------------------------|-----------------------------|-----------------------------|------------------------------|
| • CARDIOPULMONARY | Chest pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Heart Murmur | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Palpitations | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| • GENITOURINARY | Burning on urination | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Frequency of urination | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| • GASTROINTESTINAL | Heartburn | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Abdominal pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Diarrhea | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Vomiting | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| • PSYCHOLOGICAL | Mood changes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| • SLEEP PATTERN | Snoring | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Stop breathing during sleep | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Daytime sleepiness | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| • ENDOCRINE | Heat intolerance | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Cold intolerance | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Excessive thirst | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Low/high thyroid | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| • NEUROLOGIC | Weakness | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Numbness | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| • MUSCOSKELETAL | TMJ Disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| • IMMUNOLOGIC | Frequent infections | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Immune disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| • HEMATOLOGIC | Easy bruising | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Bleeding Gums | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Prolonged bleeding | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| • GENERAL | Nausea | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Weight gain | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Weight loss | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | Fatigue | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

• **FAMILY HISTORY:**

Does anyone in your family have any of these conditions?

- Hayfever Who? _____
- Sinus problems Who? _____
- Skin rashes/facial or lip swelling Who? _____
- Asthma Who? _____
- No one in my family has allergies.

MATERNAL HISTORY:

- Living AGE: _____ Any medical problems? No Yes; _____
- Deceased at age: _____ Cause of death: _____

PATERNAL HISTORY:

- Living AGE: _____ Any medical problems? No Yes; _____
- Deceased at age: _____ Cause of death: _____

Do you have any children?

- No
- Yes. Do they have any medical problems? No Yes _____

• **ENVIRONMENTAL HISTORY: HOME**

Do you live in a:

- House
- Apartment
- Townhouse/Condo/Duplex

- Does anyone in the house smoke? No Yes
- Is there smoking in the bedroom No Yes
- Do you have any pets? No Yes, I have, _____
- Are they allowed to come in the bedroom? No Yes
- Are they bathed? No Yes

What type of heating do you have in the house?

- Central furnace with forced-air heating
- Wall heaters
- Radiant-heating system
- How old is the system? _____ years old.
- The heating system is new.

Has the system been professionally cleaned?

- Yes, how long ago? _____
- Not since I've lived in the house.
- I don't know.

- Are there special allergy filters in the heating system? No Yes
- Do you have air-conditioning? No Yes

BEDROOM

Do you have carpeting in the bedroom? No Yes

I have _____ floors in the bedroom.

What type of vacuum cleaner do you use? _____

Do you sleep on any type of feather bedding?

- No
- Yes Pillow Down comforter Feather bed

What type of bed do you sleep on? Tempurpedic mattress Standard mattress Waterbed
Do you have an air-purifier in the bedroom? No Yes, it runs _____hours a day.

WORK ENVIRONMENT:

Have your allergies affected your work, relationships or your recreational activities?

- No
- Yes, please explain. _____

Please answer the questions below if you are frequently bothered by skin rashes or hives.

Current Soap: _____

Are moisturizers used daily? No
 Yes , what product? _____

What other skin care products do you use on a regular basis? _____

What laundry detergent is used at home? _____

Do you use fabric softeners? No
 Yes, what product? _____

ADDITIONAL COMMENTS:

Please use this space to expand on any issues you would like us to be aware of:

