

THE ALLERGY AND ASTHMA CLINIC

ANDREW C. ENGLER, M.D.

BROOKE LEON, N.P.

ELISABETH DENKER, N.P.

***Please plan on spending 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 Dr. Engler and our Nurse Practitioners, Brooke Leon, N.P and Elisabeth Denker, N.P, 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 24 hours prior to any scheduled appointment to allow us to give the appointment time to another patient. Cancellations with less than 24 hours notice or "no-shows" will be subject to a \$50.00 charge.

290 Baldwin Avenue San Mateo, CA 94401

Ph: (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
- 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: _____ SaO₂ _____

• **SYMPTOM PROGRESSION:**

- My symptoms have been unchanged for some time.
- My symptoms have been getting worse over the past few;
 - week
 - months
 - year

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? _____

• **ALLERGY HISTORY:**

Have you been treated for allergies in the past?

- No
- Yes

Did you see an allergist? NO YES 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? NO YES

Did you have any significant reactions to your allergy shots? NO 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
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Please list **over-the-counter** allergy medications (non-prescription) you are currently taking.

MEDICATION	DOSE	HOW OFTEN	DOES IT HELP?	SIDE EFFECTS
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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. Clarinex 5 mg	_____	_____	_____	_____
3. Claritin/loratadine 10 mg	_____	_____	_____	_____
4. 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? _____

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.

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Elevated cholesterol |
| <input type="checkbox"/> Gastroesophageal reflux (GERD) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease/Hepatitis |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other _____ |

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

MEDICATION	DOSE	HOW OFTEN	FOR WHAT CONDITION
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• **SMOKING HISTORY:**

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 _____.

• **SURGICAL HISTORY:**

I have not had any surgeries.

Yes, I have had;

Tonsils Date: _____

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: _____

Other _____ 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 |
| • 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.

Do you sleep on any type of feather bedding?

- No
- Yes Pillow Down comforter Feather bed

Do you sleep on a waterbed? No Yes

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. _____

• **ADDITIONAL COMMENTS:**

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

