THE ALLERGY AND ASTHMA CLINIC

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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 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.*

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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?

____

____

____

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- **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 Date: ________
□ No

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

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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:

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