THE ALLERGY AND ASTHMA CENTER, PC
PATIENT QUESTIONAIRE

Name ______________________ Date of Birth __________ Age ____ Sex ____ Ethnicity __________

Who referred you to our department? ______________ Who do you see regularly? ______________

Briefly describe the reason for your allergy/asthma visit:

ALLERGY HISTORY: Please check the symptoms you are having

Nose:	Lungs:	Skin:	Miscellaneous:
Nasal discharge ____	* Chronic cough ____	Eczema ____	Headaches ____
Clear ____	* Shortness of breath ____	Hives (welts) ____	Irritability ____
Colored ____	* Wheezing ____	Dry skin ____	Hard to awaken ____
Sneezing ____	* Tightness in Chest ____	Frequent Rashes ____	Tires easily ____
Sniffing ____	* If yes, note box below		Poor weight gain ____
Post nasal drip ____		Eyes:	Weight loss ____
Congestion ____	Exercise Intolerance ____	Redness ____	Fevers ____
Mouth breathing ____	Sputum or Phlegm ____	Tearing ____	Chills ____
Nasal voice ____	Pneumonia ____	Itching ____	Night sweats ____
Snoring ____	Bronchitis ____	Swelling ____	Joint/muscle problems ____
Polpys ____	Frequent Colds ____		Fainting/dizzy ____
Can't taste/smell ____	Frequent Croup ____	GI:	Depression ____
Nosebleeds ____		Heartburn ____	Anxiety ____
	Throat:	Nausea ____	Painful urination ____
Ears:	Itching ____	Vomiting ____	Abnormal periods ____
Frequent ear infections ____	Sore throats ____	Diarrhea ____	Recent changes in your health ____
Ear tubes/fluid ____	Throat clearing ____	Constipation ____	
Ear pain ____	Bad breath ____	Greasy fatty stools ____	
Hearing loss ____	Hoarse voice ____		
Speech problems ____			

* Cough: Waking up in the AM ____ Throughout the day ____ Awakened at night ____
  With exercise ____ Dry and tight ____ Productive ____
  How often: daily ____ 3 times a week ____ once a week ____ once a month ____
* Shortness of breath: During exercise ____ While resting ____ Awakened at night ____
* Wheezing/Chest tightness: With exercise ____ Awakened at night ____ With colds ____

How long have you (the patient) had these symptoms? __________ Time missed from school/work in the last year? __________

Have you (the patient) ever been treated emergently for an allergic reaction? Y N Explain: ______________

Have you (the patient) been tested for allergies? Y N What year? ________ Findings? ______________

Have you (the patient) received allergy shots? Y N If yes, did they help? Y N

Do you (the patient) have any problems eating certain foods? Y N If yes, please list: ______________

Have you ever had an allergic reaction to a stinging insect? Y N If yes, please list ______________

Which of the following make your symptoms worse?

____ Spring	____ Morning	____ Smoke	____ Indoors	____ Dust
____ Summer	____ Afternoon	____ Strong odors	____ Outdoors	____ Mold
____ Fall	____ Evening	____ Cold air	____ Basement	____ Plants/grasses
____ Winter	____ While Sleeping	____ Weather changes	____ Work/school	____ Animals
____ Colds/flu	____ Exercise	____ Wind	____ Rain	____ Emotions

Medications

List all medications that you are taking. Include those you buy / use without a prescription.

Include dosage and how many times a day you take the medications	

Please bring all of your medications with you to your appointment!!

Are you allergic to any medications? Y N If yes, list medication(s) and reactions: ______________________

____

Past Medical History

Significant childhood illnesses: ______________________

Other medical problems (Diabetes, Heart Disease, Kidney Disease, High Blood Pressure, Arthritis, Cancer, etc) :

____

Hospitalizations: Y N If yes, specify and give year: ______________________

Surgeries: Y N If yes, specify and give year: ______________________

Has patient ever had any of the following tests? Indicate year and place done:

Chest X-Ray? ____________ Sweat test? ____________ Breathing test? ____________

Sinus X-rays or CT Scan? ____________ Cardiac tests (EKG, echo, stress test) ____________

Do you (the patient) have a history of ?

_____ Asthma	_____ Eczema	_____ Food reactions	_____ Tuberculosis
_____ Hayfever	_____ Rashes	_____ Drug reactions	_____ Migraine headaches
_____ Frequent colds	_____ Hives or swelling	_____ Insect reactions	_____ Bee sting reactions
_____ Sinus infections	_____ Skin infections	_____ Croup	_____ Bronchiolitis/RSV
_____ Ear infections	_____ Pneumonia	_____ Bronchitis	_____ Latex Allergy

Are any of these recurring? N Y Explain: ______________________

____

Immunizations:

Are your (the patient) immunizations up-to-date? Y N Do you receive an annual flu vaccine? Y N

Have you had (a): Pneumonia shot? Y N TB Skin Test: Y N Chicken Pox? Y N

Birth History : Birth weight ____________ Complications? ______________________

As an infant did you (the patient) have: Colic ______ Eczema ______ Many formula changes ______

Breathing problems _____ Any adverse reactions to immunizations _____ Constant runny nose______

Family History

Mother: Age if living _____ Good Health / Medical Problems: ___________________________
Age at death ___________ cause of death ___________________________
Father: Age if living _____ Good Health / Medical Problems: ___________________________
Age at death ___________ cause of death ___________________________

Please identify if parents (F / M), brother (B), sister (S), children (C) grandparents (GM /GF) have any of the conditions listed:

	Asthma	Hayfever	Eczema	Hives	Sinus Problems
Mother (M)					
Father (F)					
Sibling (S) (B)					
Sibling (S) (B)					
Child (C)					
Child (C)					
G'parent (GM/GF)					

Autoimmune Disease _______ Heart Disease ______ Emphysema ______ Repeated infections ______
Arthritis ______ High Blood Pressure COPD ______ Cystic Fibrosis _______

Does patient have any children? Y N If yes, list ages and any other medical problems___________________________

Does patient have any siblings? Y N If yes, list ages and any other medical problems ___________________________

Environmental History

Type of home: House Apartment Mobile home Where: Rural City Edge of town

Age of the home? __________ Number of years in your present home? ________________

Heat: Gas furnace Gas fireplace Oil Electric Hot water Wood furnace Wood stove Wood fireplace

Air Conditioning? Y N Central _____ Window _____ Swamp cooler ______ Dehumidifier? Y N

Air Cleaner? Y N What type? ___________________ Humidifier? Y N Do you change the filters regularly? Y N

Home Flooring: (circle all that apply) Wood Carpet Vinyl Tile

Patient's Bedroom: Flooring ________________ Is it a basement bedroom? Y N

Mattress: How old? _______ Encased in an allergy cover? Y N

Pillow: How old? _______ Encased in an allergy cover? Y N Synthetic / Feather

Stuffed animals? Y N

Household plants: Y N How many? _________ In bedroom ? Y N

Indoor pets: Y N Which ones: ___________________________

Pets in bedroom: Y N Which ones: ___________________________

Do other members of the household smoke? Y N Who: ___________________

Does anyone smoke in the house or car? Y N Who: ___________________

Occupational / Social History

Place of birth: ____________________ How long have you lived in Western Montana? __________

School: Is patient in school? Y N Grade: ______ Where? ______________________________

Smoking history: Do you (the patient) smoke? Y N Year started: ________ #/day: ______________

Did you smoke in the past? Y N Year quit: __________ #/day: __________

Does patient use chewing tobacco? Y N ______________________________

Does patient drink alcohol regularly? Y N ______________________________

Does patient use any illegal drugs? Y N ______________________________

Employment: Do you work? Y N Where? ______________________________

Gas or Chemical fume exposure: Y N

Recent travel: Y N If yes, when and where: ______________________________

If the patient is a child:

Childcare: Does patient go to daycare? Y N # of children at daycare: ________

Pets at daycare? Y N Which ones: ______________

Second hand smoke at daycare? Y N

Mother's Name: ________________ Occupation/Place of Employment: ______________________

Father's Name: ________________ Occupation/Place of employment: ______________________

Circle the answers that best describe your family.

My natural parents are: married not married divorced widowed remarried

If parents do not live in the same household, how much time is spent with each parent? ______________

# of siblings: ____________

Additional notes or concerns:

Thank you for taking time to complete this form.