ALLERGY AND ASTHMA HEALTHCARE

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_____ _____
(Your name/child's name) **(Nickname?)**

_____
(Age)

_____
(Date of visit to our office)

_____
(Name of parent or guardian if applies)

Welcome to Allergy and Asthma Healthcare! It is our obligation to provide for you the best care we can offer for your allergy and asthma needs. By using the following questionnaire, please describe your symptoms to us in as detailed a manner as possible so we will gain a full understanding of what you are experiencing. Please be careful to relate all answers to your own experience, not to previous advice on allergy or skin tests. Answer only the questions that apply to you.
All information will be considered confidential

PLEASE NOTE THAT THESE PAGES WILL BECOME A PART OF YOUR OFFICIAL RECORD AT OUR OFFICE.

C.C: What is the main reason for your visit today?
IF YOU HAVE EXPERIENCED A SEVERE ALLERGIC REACTION, PROCEED TO PAGE 5 AND COMPLETE THOSE QUESTIONS THAT APPLY.

Please tell us what symptoms you are experiencing. Check all that apply.

□ **Cough**

Frequency
□ Daily
□ Weekly
□ Monthly
□ Rarely

Does the cough affect your sleep?
□ Yes How many times in 1 week? ___ or ___ days a week
□ No

Are your activities limited by the cough?
□ Talking
□ Daily routine activities?
□ Exercise

Other concerns about the cough you would like to discuss
_____
_____

□ **Wheezing**

Frequency
□ Daily
□ Weekly
□ Monthly
□ Rarely

Does the wheeze awaken you from sleep?
□ Yes How many times in 1 week? ___ or ___ days a week
Around what time? _____o'clock in the AM
_____o'clock in the PM
□ No

Are your activities limited by wheezing?
□ Talking
□ Daily routine activities?
□ Exercise

□ **Shortness of Breath** *(a feeling of being short-winded)*

Frequency
□ Daily
□ Weekly
□ Monthly
□ Rarely

Do you wake up from sleep with difficulty breathing?
□ Yes How many times in 1 week? ___ or ___ days a week
Around what time? _____o'clock in the AM
_____o'clock in the PM
□ No

Are your activities limited by breathing difficulty?
□ Talking
□ Daily routine activities?
□ Exercise

What helps you breathe better? _____

DOCTOR'S NOTES

C.C. Please tell us what symptoms you are experiencing. Check all that apply

□ **Phlegm/Mucous**

Color

□ Clear
□ White
□ Yellow/Green
□ Bloody

Consistency

□ Watery
□ Thick

Are you constantly having to clear your throat?

□ Yes
□ No

Are you frequently coughing or gagging?

□ Yes
□ No

□ **Nasal/Sinus Symptoms**

Sneezing
Itching
Post Nasal Drip
Runny nose (What makes your nose run?)

□ Cold weather
□ Eating
□ Certain smells

Nose bleeding
STUFFINESS/NASAL CONGESTION

□ Everyday
□ In the morning only
□ Any time of the day
□ Around certain triggers

Please rate severity: (circle)

1 2 3 4 5 6 7 8 9 10
(least) *(worse)*

Does the congestion affect your ability to sleep?

□ Yes
□ No

Does the congestion affect your ability to smell or taste?

□ Yes
□ No

HEADACHES

Where are your headaches located?

□ Forehead
□ Temples
□ Cheekbones
□ Other: _____

SINUS INFECTIONS

□ 1 - 2 times a year
□ 3 - 5 times a year
□ > 6 times a year

Usual duration of antibiotic courses

□ 7 - 10 days
□ 30 days or more

Any X-RAYS or evaluation by an Ear, Nose and Throat specialist?

□ Yes When: _____ Where: _____
□ No

Have you had sinus surgery in the past: □ No
□ Yes When: _____ Where: _____

DOCTOR'S NOTES

C.C. Please tell us what symptoms you are experiencing. Check all that apply

EYE SYMPTOMS

- □ Itching
- □ Burning
- □ Redness
- □ Redness
- □ Swelling
- □ Tearing
- □ Mucous
- □ Crusting

THROAT/ROOF OF MOUTH SYMPTOMS

- □ Itching
- □ Soreness
- □ Hoarseness / loss of voice
- □ Frequent bouts of throat infections

EAR SYMPTOMS

- □ Itching
- □ Popping
- □ Pain
- □ Stuffiness
- □ Frequent ear infections
- □ Previous ear tube placement
- □ Other history:_____

SKIN SYMPTOMS

LOCATION OF INVOLVEMENT

- □ Scalp
- □ Face
- □ Neck
- □ Arms
- □ Hands
- □ Legs
- □ Feet
- □ Chest
- □ Abdomen
- □ Back

SYMPTOMS

- □ Itching
- □ Swelling
- □ Hives

  Size?
  - Pinpoint
  - Coin sized
  - Size of an orange
  - Massive

  Duration?
  - Minutes
  - Less than 24 hours

  Are there any residual marks?
  - Redness
  - Bruising

- □ Eczema
  - Moisturizer:_____
  - Soap:_____
  - Daily Routine:_____

DOCTOR'S NOTES

HPI: Please tell us more about your symptoms. Check all that apply.
(Please describe the PATTERNS of those you listed)

How long have you been bothered by the above mentioned symptoms?

_____ Days
_____ Weeks
_____ Months
_____ Years

When are your symptoms at their worse?

- □ Year Round
- □ Winter *(circle)* Dec Jan Feb
- □ Spring *(circle)* Mar Apr May
- □ Summer *(circle)* Jun Jul Aug
- □ Fall *(circle)* Sept Oct Nov

Which of the items below trigger a worsening of your symptoms ?

Irritants

- □ Tobacco smoke
- □ Perfume
- □ Powder
- □ Detergents
- □ Aerosols
- □ Motor fumes
- □ Hair spray
- □ Chemical Fumes

Weather Changes

- □ Humidity
- □ Cold temperatures
- □ Pollution (i.e. "bad air days")
- □ Changes in temperature
- □ Rainy days
- □ Dry / windy weather

Animals

- □ Dog
- □ Cat
- □ Birds
- □ Horses
- □ hamsters / guinea pigs / rabbits
- □ Mice/rats
- □ Other:_____

Infections

- □ Colds / Flu
- □ Bronchitis / pneumonia

Contacts *(circle those that apply)*

- □ poison ivy / cut grass / cut flowers / hay / Christmas trees
- □ dust / wool blankets / feathers / rugs
- □ furs / jewelry
- □ soaps / shampoos / lotions

Miscellaneous

- □ Laughing
- □ Fatigue
- □ Traveling
- □ Emotions
- □ Exercise or other strenuous activities

Other:_____
_____

DOCTOR'S NOTES

SEVERE ALLERGIC REACTIONS: (If applies)

If you have experienced a severe allergic reaction, please answer the following questions to help us understand the course of events.

BEE STING / DRUG ALLERGIES

Date of reaction:_____

Previous stings / exposure to suspected drug :_____

□ Yes Any reaction at that time? _____

□ No

Symptoms: *(indicate the order of occurrence by number)*

_____ Flushing / Redness
_____ Hives
_____ Swelling at sting / injection site
_____ Swelling of other areas
_____ Throat closure / inability to talk or swallow
_____ Coughing
_____ Difficulty breathing
_____ Lightheaded
_____ Unconsciousness
_____ Other: _____

How soon after the sting / exposure did the symptoms start?

□ 15 - 30 minutes
□ Hours
□ Days
□ Weeks

Emergency Room / Emergency Medical services / Hospitalization

Where: _____

What was done: _____

_____

_____

_____

What Medicines did you take at home after discharge?

_____

_____

_____

FOOD ALLERGIES:

Date of reaction:_____

Suspecte food(s):	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How soon after eating did the symptoms start?

□ 15 - 30 minutes
□ Hours
□ Days
□ Weeks

Emergency Room / Emergency Medical services / Hospitalization

Where: _____

What was done: _____

_____

_____

What Medicines did you take at home after discharge?

_____

DOCTOR'S NOTES

PAST MEDICAL / SURGICAL HISTORY

Please list any current medical conditions for which you see a doctor ot for which you take medications on a regular basis:

_____
_____
_____
_____
_____

If Pregnant:

Due Date: _____

Name of Obstetrician: _____ Ph.# _____

Previous Surgeries:

_____ When: _____
_____ When: _____
When: _____

CURRENT MEDICATIONS AND DOSAGES

_____ _____
_____ _____
_____ _____
_____ _____

OVER THE COUNTER MEDICATIONS/VITAMINS/ ETC.

_____
_____

DRUG ALLERGIES *(LIST REACTIONS)*

_____ _____
_____ _____
_____ _____
_____ _____

IMMUNIZATIONS: UP TO DATE? *(circle)* Yes No

PAST ALLERGY/ASTHMA TREATMENT HISTORY

Allergy Testing

□ Skin test When: _____
Where: _____
□ Blood test When: _____
Where: _____

To what were you found to be allergic when you were tested?

_____

Allergy injections:

□ Yes How long did you receive them? _____
□ No

Sinus X-rays: Dates: _____

Asthma Dates: _____
ER visits : Dates: _____
Recent chest x-rays: Dates: _____

Yearly Flu Shots? □ NO □ YES Date of last Flu shot?: _____

What medications have you tried in the past to relieve your allergy or asthma symptoms?

Name	Effective ?	
_____	Yes	No
_____	Yes	No
	Yes	No

DOCTOR'S NOTES

ADDITIONAL HISTORY FOR CHILDREN BEING EVALUATED

(Please answer the following in addition, if your child is being evaluated today; otherwise proceed to the next pages)

Problems in Pregnancy?

□ Yes *(please list)* _____

_____

□ No

Problems during labor and delivery?

□ Yes *(please list)* _____

_____

□ No

Prematurity:

Weeks gestation

NICU?

□ Yes How long? _____

□ No

Required Oxygen?

□ Yes How long? _____

□ No

Feeding History

Breast Fed:

□ Yes How long? _____

□ No

Formula Fed:

□ Yes How long? _____

□ No

Any problems with feeding? □ No

□ Projectile vomiting

□ Spitting up excessively

□ Colic

Any problems with transition to:

□ Cow's milk *(list)* _____

□ Solid foods *(list)* _____

Has your child had problems currently or in the past with:

□ Croup

□ Bronchitis

□ Bronchiolitis

□ Pneumonia

□ Ear infections Tubes? *(circle)* Yes No

□ Sinus infections

□ Throat infections

□ Chicken pox

□ Measles / mumps

□ Flu

□ Other: _____

DOCTOR'S NOTES

REVIEW OF SYSTEMS

(Other problems that may be bothering you) *Circle all that apply.*

GENERAL: fever, weight loss / gain, muscle aches
ENT: voice problems, lumps in the neck, throat clearing
RESPIRATORY: emphysema, COPD, lung edema, blood in sputum
CARDIOVASCULAR chest pain, high blood pressure, heart failure
ABDOMEN: pain, nausea, vomiting, cramps, diarrhea, blood in stools, heartburn, reflux, regurgitation
NEUROLOGICAL: headaches, migraines, seizures
OTHER: _____
_____
_____

SOCIAL HISTORY:

Occupation: _____

Length of time at establishment: _____ months
_____ years

Chemical exposures (if any):

_____

Number of missed days due to illness in one year:_____

Grade in school (if student): _____

Number of missed days due to illness in one year:_____

Childcare arrangements (for infants/toddlers/preschoolers)

□ Daycare How many times a week? _____
□ Home How many kids in it? _____

Smoke Exposure

□ Self Packs per day _____ Number of years? _____
□ Passive tobacco exposure
□ Home
□ Work

FAMILY HISTORY:

Asthma? (Please list affected blood-related family members)

_____
_____
_____

Allergy? (Please list affected blood-related family members)

_____
_____
_____
_____

OTHER ? (Please list affected blood-related family members)

_____
_____
_____

DOCTOR'S NOTES

ENVIRONMENTAL HISTORY

Please provide a description of your home environment.
For children who has dual residencies, please indicate which home is being described here, although it would be best to describe both places if possible.

Type of domain: How old?

How long have you lived there _____
- □ Apartment _____
- □ Duplex _____
- □ Townhouse _____
- □ Single family home _____
- □ Farmhouse _____
- □ Mobile home _____

Location of house:
- □ City
- □ Suburbs
- □ Rural

Whithin a few mile radius from home is there:
- □ Lake, pond, creek, river
- □ Factory
- □ Farm field

Inside the home; do you have:
- □ Fireplace How often it is used?_____
- □ Wood-burning stove How often it is used?_____
- □ Furnace filter How often is it changed?_____
- □ Indoor plants How many?_____ Which rooms_____
- □ DUSTY?
- □ Basement (or crawl space;)
  - □ Musty
  - □ Dry
  - □ Dehumidifier on
  - □ Finished
  - □ Unfinished
- □ Tobacco smoke exposure

Do you have pets: (circle all that apply)
- □ **Cat(s)** #_____ indoor outdoor sleeps in bedroom
  How long has the pet been with the family? _____years
- □ **Dog(s)** #_____ indoor outdoor sleeps in bedroom
  How long has the pet been with the family? _____years

- □ **Hamster / guinea pig / rabbit / mice** #_____
- □ **Other:** _____

Your bedroom (or child's bedroom, if child is the patient)

Flooring
- □ Carpet
- □ Hardwood floor
- □ Linoleum

Bedding
- □ Mattress/box spring
- □ Waterbed
- □ Other mattress type:_____
- □ Pillows: *(circle)* feather foam polyester-filled

Allergy-proofing
- □ In room filter
- □ Dust mite encasing

DOCTOR'S NOTES