Columbia Asthma & Allergy CLINIC

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New Patient History Questionnaire

Date of Visit:_____

Patient Name:_____ DOB:_____ Gender:_____

Referred by:_____ Primary Provider:_____

Briefly state what symptoms are bringing you here:_____

_____

Have you ever seen a specialist (allergist, dermatologist, ENT, pulmonologist) for allergy-related problems? ❑ yes ❑ no

If yes, who?_____

Environmental Allergy Symptoms (Check all that apply) If none, check here: ❑

Nose / Sinuses / Throat
- ❑ sneezing
- ❑ itching nose
- ❑ congestion / stuffiness
- ❑ runny nose (❑clear ❑colored)
- ❑ nose bleeds
- ❑ snoring
- ❑ loss of smell
- ❑ nasal polyps
- ❑ history of deviated septum
- ❑ post nasal drip
- ❑ scratchy throat
- ❑ dry throat
- ❑ sore throat
- ❑ constantly clearing throat
- ❑ headache
- ❑ sinus pressure / pain
- ❑ frequent sinus infections (# per year_____)
- ❑ Nasal / Sinus Procedures (circle): surgery, sinus x-ray, sinus CT Date(s):_____

Eyes
- ❑ itchy
- ❑ watery
- ❑ redness
- ❑ eyelids swollen
- ❑ sensitive to light
- ❑ blurred vision

Ears
- ❑ itching
- ❑ plugging
- ❑ discharge
- ❑ aching/pain
- ❑ hearing loss
- ❑ recurrent ear infections

Previous Allergy Testing/Treatment
- ❑ Allergist evaluation (Date:_____)
- ❑ ENT evaluation (Date:_____)
- ❑ skin testing (Last Date:_____)
- ❑ blood testing (Last Date:_____)
- ❑ allergy shots (for ____ years and stopped in _____ (year)

Symptoms are aggravated by:
- ❑ tobacco smoke
- ❑ exercise
- ❑ cold air
- ❑ animals
- ❑ workplace or school
- ❑ dusting or vacuuming
- ❑ odors or scents
- ❑ yard work
- ❑ weather change
- ❑ being outdoors
- ❑ aspirin / related medications
- ❑ other: _____

Symptoms first began:
- ❑ childhood at age _____
- ❑ adult at age _____

Symptoms occur in:
- ❑ spring ❑ summer
- ❑ fall ❑ winter

Symptoms interfere with:
- ❑ sleep ❑ work/school
- ❑ recreation

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Current Medications (Prescription, Over-the-Counter, Vitamins, Supplements, etc.)		
Medication Name:	Strength / Dose / Frequency:	Start Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Previous Medications Tried:_____		

Medication / Drug Allergies	If No Drug Allergies, check here: ❑	
Drug/Medication Name:	Description of Reaction:	Reaction Date:
_____	_____	_____
_____	_____	_____

Asthma / Respiratory Problems (Check all that apply) — If none, check here: ❑

❑ Asthma diagnosed in year _____
❑ Asthma NOT diagnosed, but:
- ❑ frequent bronchitis/croup
- ❑ respiratory troubles as a child
- ❑ inhalers like albuterol help
- ❑ steroid medicine helps

❑ COPD/emphysema diagnosis (year_____)
❑ cough
- ❑dry
- ❑ wet / mucus
  - ❑clear, ❑yellow/green, ❑bloody

❑ chest tightness
❑ chest pain
❑ shortness of breath
❑ wheezing
❑ lips and/or fingernails turn blue

Symptoms first began:
❑ childhood at age _____
❑ adult at age _____

Previous Testing/Treatment
❑ Pulmonologist evaluation
Last Date:_____
❑ Pulmonary function testing
Date(s):_____
❑ Chest x-ray
Date(s):_____

❑ ER visits
- How many?_____
- Last visit:_____

❑ Hospitalized _____ times
Last hospitalization:_____

❑ Oral steroids: ____ courses/year
❑ Albuterol use:
- ❑ ____ times per week
- ❑ ____ times per month

Symptoms are aggravated by:
❑ tobacco smoke
❑ exercise
❑ cold air
❑ animals
❑ workplace or school
❑ dusting or vacuuming
❑ odors or scents
❑ yard work
❑ weather change
❑ being outdoors
❑ aspirin / related medications
❑ other: _____

Symptoms occur in:
❑ spring ❑ summer
❑ fall ❑ winter

Symptoms interfere with:
❑ sleep ❑ work/school ❑ recreation

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Skin Problems (Check all that apply)		If none, check here: ❑
❑ itching ❑ dry, scaly skin ❑ eczema ❑ welts, hives ❑ rash ❑ skin swelling ❑ recurrent skin infections **Location of skin problems:** _____	**Symptoms first began:** ❑ childhood at age _____ ❑ adult at age _____ **Previous Testing/Treatment** ❑ Dermatologist evaluation Last Date:_____ ❑ medications (see medication list) ❑ moisturizers ❑ other:_____	**Symptoms are made worse by:** _____ _____ _____ **Symptoms interfere with:** ❑ sleep ❑ work/school ❑ recreation

Food Allergies		If No Food Allergies, check here: ❑
Previous food allergy testing? ❑no ❑yes (If yes, ❑skin test ❑blood test Date(s):_____)		
Food(s) Causing Reaction:	Description of Reaction:	Reaction Date:
_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____

Latex, Insect Stings, Chemicals, and Other Allergic Reactions		If No Other Allergies, check here: ❑
Item Causing Reaction:	Description of Reaction:	Reaction Date:
_____ _____	_____ _____	_____ _____

Other Past Medical History

Immunizations: ❑ up to date ❑ not up to date
Have you received: 1)Flu vaccine in past year: ❑ yes ❑ no 2)Pneumonia vaccine: ❑ yes in _____(year) ❑ no

Surgeries / Hospitalizations (details and date):_____

Other Medical Conditions: ❑ None

❑ Diabetes	❑ Thyroid Disease
❑ Seizures	❑ Kidney Disease
❑ Heart Disease	❑ Liver Disease
❑ High Blood Pressure	❑ Other Lung Diseases_____
❑ GERD	❑ Other_____

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Family History						If Unknown, check here: ❑
	Father	Mother	Brother(s)	Sister(s)	Child(ren)	Grandparent(s)
Hayfever / Allergies:	❑	❑	❑	❑	❑	❑
Sinus Trouble:	❑	❑	❑	❑	❑	❑
Asthma:	❑	❑	❑	❑	❑	❑
Frequent Bronchitis:	❑	❑	❑	❑	❑	❑
Eczema:	❑	❑	❑	❑	❑	❑
Hives:	❑	❑	❑	❑	❑	❑
Migraine Headaches:	❑	❑	❑	❑	❑	❑
Thyroid Disease:	❑	❑	❑	❑	❑	❑
Food Allergies:	❑	❑	❑	❑	❑	❑
Other:_____	❑	❑	❑	❑	❑	❑
Autommune Disease (in any relatives):_____						

Social History

Occupation:_____
Recent Travel History:_____
Marital Status: ❑Single ❑Married ❑Divorced/Sep. ❑Widowed
Exercise:_____
Hobbies:_____
Special Diet?:_____

Current smoker? ❑no ❑yes, ___ packs per day
Past smoker? ❑no ❑yes, ___ packs per day
for ___ years. Quit in _____.
Alcohol Use: ❑None ❑1-5 drinks per week
❑More than 5 drinks per week
Recreational Drug Use (confidential): ❑yes ❑no

Environmental History

Primary residence: ❑House ❑Apartment/Condo/Townhouse
❑Mobile Home **Location**: ❑city/suburban ❑rural
Residence is ____ years old and have lived there for ___ years.
Previously lived in (city/state/country):_____

Does your home have a basement? ❑no ❑yes
(if yes, ❑finished ❑unfinished ❑dry ❑damp ❑musty)
History of water damage in home? ❑no ❑yes
Is there mold visible in the home? ❑no ❑yes
Smokers in the home? ❑no ❑yes

Pets: ___dog(s) ___cat(s) Other:_____
❑indoor ❑outdoor ❑allowed in bedroom

Heating: ❑central ❑electric ❑gas ❑radiator
❑wood fireplace ❑gas fireplace
Air Conditioning: ❑central ❑in-window ❑fans
Filter System: ❑yes ❑no
Humidifier: ❑yes ❑no
Flooring:
In main areas: ❑carpet ❑laminate ❑hardwood
In bedroom: ❑carpet ❑laminate ❑hardwood
Bed: ❑mattress/boxspring ❑latex ❑foam
❑waterbed ❑other_____
(Allergy encasement? ❑yes ❑no)
Pillows: ❑feather ❑non-feather
(Allergy encasements? ❑yes ❑no)