Name: _____ **DOB:**_____ **Date**:_____

New Patient Questionnaire (Circle all that apply)

Have you seen an allergist before ? Yes No
If yes, who was the doctor?

_____

Name the biggest problem(s) you would like the doctor to address today?

_____

_____

Nose symptoms:

1. Do you have a runny nose more than four days per week? Yes NO
2. Do you experience congestion more than four days per week? Yes NO
3. Do you experience nasal itching? Yes No
4. How would you describe your sense of smell? Good Bad
5. Do you experience a drip in the back of your throat or post nasal drip ? Yes No
6. What other nasal symptoms are you experiencing?

   _____

7. **Are your symptoms related to any particular time of year?**
   All-year round ☐ spring ☐ summer ☐ fall ☐ winter ☐

8. **What treatments have you tried for your nose? List specific medications.**

   _____

   Does the medication help with any symptom? Yes NO

   If yes, list the Nasal symptoms that are improved by taking/using your current medications.

   _____

9. **What triggers have you noticed that contribute to your symptoms or cause your symptoms?**
   Cat/dog ☐ dust ☐ temperature changes ☐ seasonal changes ☐ other

Other: _____

10. **In the past 12 months, how many courses of antibiotics did you need for sinus infections? _____.**

11. **Are the sinus infections usually at the same time of year as your nasal symptoms?** Yes NO

12. **What is the name of the antibiotics that were given?** _____

13. **Do you use afrin, 4 way, neosynephrine, Oxymetazoline, or a similar medication for quick nasal congestion relief regularly?** Yes ◯ No ◯

Eye symptoms:

1. Do you experience watery, itchy eyes at the same time as your nasal symptoms? Yes ◯ No ◯
2. If so, do you currently use any eye drops for treatment? Yes ◯ No ◯

Do you have asthma? Yes ◯ No ◯

1. **At what age were you diagnosed with asthma? _____**
2. **Have you ever been hospitalized for asthma?** Yes ◯ No ◯
3. **Have you ever needed to be in the ICU (intensive care unit) for asthma?** Yes ◯ No ◯
4. **In the past month, how many days per week on average do you need to use your rescue inhaler or albuterol/proair/ventolin during the day?** **0** 1 2 3 4 5 6 7
5. **In the past month, how many nights per week do you wake up with a cough, shortness of breath, chest tightness?** **0** 1 2 3 4 5 6 7
6. **Do you use any other inhaler medications for asthma (symbicort, flovent, advair, Spiriva)?** Yes ◯ No ◯
7. **If yes, please list ones you currently use and have used in the past.**_____

8 In the past 12 months, have you been admitted to the hospital or required to be kept over night? Yes ◯ No ◯

9. In the past 12 months, how many times did you need to go to the emergency room for asthma treatment? _____

10. In the past 12 months, how many times did you need to take a steroid medication by mouth or prednisone for an asthma exacerbation? Circle one. 0-2 ◯ or ◯ >2

11. **Do you use a nebulizer machine in addition to an inhaler?** Yes ◯ No ◯

12. What are your asthma triggers? _____

13. When was you last pulmonary function test (PFT)? This is when you blow really hard into a tube and get readings from a machine. This helps the doctor assess your asthma status.

_____

Atopic Dermatitis

1. **Do you have eczema or atopic dermatitis ?** Yes ◯ No ◯
2. **Is this currently a problem?** Yes ◯ No ◯
3. **At what age were you diagnosed ? _____**
4. **What medications do you use for eczema (Be specific with name)?_____**

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5. **Which doctor prescribes this for you? _____**
6. **Have you required a skin Biopsy for your skin rash?** Yes ◯ No ◯

Oral Allergy

1. **Do you experience a fuzzy, itchy, tingling sensation with any fresh fruits or vegetables?** Yes ◯ No ◯

Food Allergy/Intolerance

1. **Do you currently avoid any foods?** Yes ◯ No ◯

If yes, which foods and why (List specific symptoms)?

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2. **Have you been diagnosed with food allergy?** Yes ◯ No ◯
3. **If yes, how were you diagnosed and who diagnosed you?**

_____

Nsaid

Can you take aspirin, Motrin, Aleve, ibuprofen, BC Powder, Pepto Bismol, Excedrin, naproxen without problems? Yes ◯ No ◯

Venom

If you get stung by a bee, wasp, hornet, yellow jacket, or fire ant, do you need to seek medical attention, or go to the emergency room? Yes ◯ No ◯

Urticaria

1. **Do you experience hives ?** Yes ◯ No ◯
2. **Have you been able to identify triggers?** Yes ◯ No ◯
   If yes, what are they? _____
3. **Is there scarring or dark marks when the hives are gone?** Yes ◯ No ◯
4. How long does one individual hive last? _____

Dysphagia
Do you currently experience problems swallowing cake-like consistencies, steak, or other foods? Yes ◯ No ◯

1. **If yes, is this seasonal ?** Yes ◯ No ◯
2. **Constant?** Yes ◯ No ◯
3. **When did the symptoms start? _____**
4. **Have you seen a GI doctor or gastroenterologist ?** Yes ◯ No ◯
5. **If so, Who? _____**
6. **Were Biopsies performed?** Yes ◯ No ◯

Infection History
Have you ever been diagnosed with pneumonia? Yes ◯ No ◯

If Yes, How many in one year? _____

How many ear infections in one year have you been diagnosed with? _____

Have you been hospitalized to "clear" an infection? **Yes ◯ No ◯**

Have you ever had a problem with recurrent warts, molluscum, boils (staph infections), or other skin infections? **Yes ◯ No ◯**

Family History:
Who in your family has the following? First Degree relatives only (Grandparents, Mother, Father, Siblings (blood-related, children)
Asthma:
Eczema:
Food Allergy:
Drug Allergy:
Venom Allergy:
Trouble Swallowing:
Hives:
Immune Deficiency (anyone needed IVIG or replacement antibodies):
Autoimmune Disease (Lupus, Crohn's, Ulcerative Colitis, Rheumatoid arthritis etc):
Thyroid Disease:

Reflux Symptom Indicator

Name _____ Date:_____

In the past month, rate how bad these symptoms affected you. 0 = No Problems 5 = Severe

1. Hoarseness or a problem with your voice when waking up	0	1	2	3	4	5
2. Clearing your throat	0	1	2	3	4	5
3. Excess throat mucus or post nasal drip	0	1	2	3	4	5
4. Difficulty swallowing foods, liquids, or pills	0	1	2	3	4	5
5. Coughing after you eat or after lying down	0	1	2	3	4	5
6. Breathing difficulties or choking episodes	0	1	2	3	4	5
7. Troublesome or annoying cough	0	1	2	3	4	5
8. Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
9. Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5

Total: _____