Appendix 1 - New Patient Allergy History

Name _____ Age _____ Birthdate _____

Family doctor _____ Referred by: _____

1. Present illness:

a. *Briefly*, what are your most prominent symptoms?

_____

_____

b. When did they start? _____ How frequent are they? _____

c. Are they present all year round (to any degree)? _____

d. Circle the months that are especially bad: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

e. Approximately how many days of school or work are missed per year? _____

f. How often are you treated with antibiotics for sinus or chest infections? _____

g. Have you ever seen an allergist before? Yes / No Been skin tested? Yes / No On allergy shots? Yes / No

h. Have you ever had sinus surgery? Yes / No When? _____

2. Circle any of the following that make your symptoms worse:

being indoors	being outdoors	weather changes	exercise	smoke	being at work
mowing lawn	playing in / on grass	raking leaves	house dust	perfumes	menstrual periods
mold & mildew			aspirin, ibuprofen		emotions

animals (specify): _____ other : _____

3. Review of Systems: Circle any of the following that you have had in RECENT months:

Nose/Sinuses	**Lungs**	**Skin**	**General**	**Emotions**
sneezing, itching	wheezing	rashes	fever, chills	irritability
congestion	shortness of breath	hives	appetite change	anxiety
postnasal drainage	cough	eczema	weight loss	depression
runny nose	chest tightness	atopic dermatitis	dizziness	**Other**
snoring	**Eyes**	**Heart**	tiredness	migraine headaches
nasal polyps	swelling	fast heart beat	**GI**	arthritis
sleep problems	redness, itching	chest pain	heartburn	diabetes
throat mucus	watering	angina	acid taste/reflux	thyroid disease
sinus headaches	**Ears**	murmur	diarrhea	anemia
decreased smell	fluid/popping/pain	heart attack	nausea or vomiting	osteoporosis
infections/drainage	hearing loss		abdominal pain	urine leak with cough

☐ All other systems (10 point) reviewed and are negative.

4. Have you ever been diagnosed with asthma or "reactive airways" or treated with inhalers?

a. How old were you when your asthma began? _____

b. How often (per day or week) do you *use* an albuterol inhaler (Proventil, ProAir, Ventolin) or Xopenex?_____

c. How often do you *have* wheeze, shortness of breath, cough, or chest tightness? _____

d. Do asthma symptoms ever awaken you at *night*? _____

e. Has asthma interfered with your work, social or physical *activities*? _____

f. Have you been treated with oral steroids (prednisone, Medrol) in the past year? _____ How often? _____

g. Have you ever needed ER visits or hospitalization? _____ How often? _____

h. Do you have a peak flow meter? _____ "Typical" reading? _____ "Best" reading? _____

5. Are there any <u>foods</u> that cause symptoms? Yes / No Specify and explain symptoms: _____

_____

_____

6. If you have had any recent studies, please specify with approximate date and result:

a. Chest X-ray: _____

b. Sinus CT scan or X-ray: _____

c. Labs: _____

TURN OVER

7. Stinging insects: Any reactions to stinging insects (bees, wasps, etc)?
Did reaction go beyond area of sting itself? _____

8. List *other* medical diagnoses: **9. List *all* medications *and* doses (include over-the-ctr):**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

9. Are you allergic to any medications (such as antibiotics)? Yes / No Please list meds and reaction:

_____
_____

10. Social history:

a. Occupation? _____ Hobbies or activities? _____
b. Work exposures? _____
c. Married? Yes / No
d. Have you ever smoked? Yes / No If so, packs / day: _____ Years smoked: _____ Quit: _____
e. Do you drink alcohol? Yes / No If so, how much? _____

11. Family history:

a. Other illnesses in your family (list):
Father _____ Children _____
Mother _____ _____
Grandparents _____
b. Do you have a family history of? *Circle*: Asthma Nasal allergies Sinus problems Migraines Other: _____

12. Pets

Do you have pets? Yes / No If so, what ? _____ How long? _____
Are they? Indoors Outdoors Both Do they sleep in your bedroom? Yes / No
Are you exposed to any other animals? Yes / No If so, what & where? _____

13. Environmental history

a. House , apartment or mobile home ? _____ Age of dwelling: _____
b. How long have you lived there ? _____
c. Is there a basement ? Yes / No Is it finished ? Yes / No Is it damp or musty ? Yes / No
d. Is there mold or mildew growing anywhere in your home? Yes / No Houseplants ? Many / Few
e. Do you run? : humidifier dehumidifier air cleaners (type: _____)
f. Mattress: Standard mattress Water-bed Foam Futon Age of mattress? _____
g. Is your mattress and pillow covered with a plastic or dust mite-proof zipper cover ? Yes / No
h. Carpeting in bedroom? Yes / No If not, flooring is _____
i. Does *anyone* in your home smoke? Yes / No If so, who? _____
j. Have you seen cockroaches or mice or ladybugs (circle) in your home in the past 6 months? Yes / No

14. Immunizations: Have you had the pneumonia shot? Yes / No; year:_____ Do you get flu shots? Yes / No

15. Bone density: Have you ever had a bone density test (called DEXA)? When? _____

16. Additional comments: _____
_____
_____
_____
_____