advocare | Allergy & Asthma

Patient Questionnaire/History

Date:_____ Date of visit: _____

Legal patient name_____Preferred name if different _____

Date of birth_____Age____Gender M F Referring physician/Primary Doctor_____

Person providing information_____Relationship to patient _____

What is the reason for your visit? _____

Any season of the year worse for your symptoms? (circle) All year Spring Summer Fall Winter

Any triggers make your symptoms worse? (please check all that apply)

- ☐ Colds
- ☐ Smoke
- ☐ Perfumes
- ☐ Pets
- ☐ Dust
- ☐ Change in weather
- ☐ Change in temperature
- ☐ Cut Grass
- ☐ Mold
- ☐ Heat
- ☐ Pressure
- ☐ Strong Odors
- ☐ Sweating
- ☐ Activity
- ☐ Workplace/Home/School
- ☐ Other _____

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Medications

Include all prescriptions, over the counter medications, herbal meds, vitamins, and as needed medications, Use an additional sheet, or bring in a separate list if needed.

Name of Medication Dosage (ex: 20mg) Method (if not oral) Frequency (ex: 1 pill twice a day)

Previous allergy evaluation, blood work, skin tests, allergy shots, breathing tests, x-rays, CT scans and other doctors seen in the past (bring copies with you) ☐ No Previous Evaluations

Allergy History

Do you have any medication, food, bee sting, latex or x-ray dye allergies or reactions? (specify agent and reaction)

Medication Issues ☐ None

Food Issues ☐ None

Stinging Insect Issues ☐ None

Latex/Adhesive Sensitivities ☐ None

Xray Dye/RCM Issues ☐ None

Past Medical History

Do you have (or have you had) any of the following conditions? (circle)

Abnormal birth	YES	NO	Immune problems	YES	NO	Emphysema or COPD	YES	NO
Unusual childhood illnesses	YES	NO	Unusual infections	YES	NO	Diabetes	YES	NO
Asthma	YES	NO	Anxiety/panic attacks	YES	NO	Thyroid problems	YES	NO
Nasal or eye allergies	YES	NO	Depression	YES	NO	Anemia	YES	NO
Eczema	YES	NO	ADD / ADHD	YES	NO	Liver problems	YES	NO
Hives	YES	NO	Arthritis	YES	NO	Prostate problems	YES	NO
Swelling of body parts	YES	NO	Osteoporosis	YES	NO	Heartburn or reflux	YES	NO
Chronic sinus problems	YES	NO	Seizures	YES	NO	Palpitations	YES	NO
High blood pressure	YES	NO	Migraines	YES	NO	Kidney problems	YES	NO
High cholesterol	YES	NO	Cancer	YES	NO	Stroke	YES	NO

Explain any YES answers. List any other medical issues, major illnesses, or other reasons you may see a doctor

_____

_____

_____

Please list all previous surgeries, hospitalizations and emergency room visits (include dates and reasons)

Surgery history ☐ None _____

_____

Hospitalizations ☐ None _____

_____

ER Visits ☐ None _____

_____

Personal and Social History of Patient - Adult

Marital Status Never Married Married Widowed Divorced Separated Other

Number of children _____ Ages _____

Occupation _____ Employer _____ Have you missed any work or school this year due to illness? YES NO N/A If so how many days _____

Personal and Social History of Patient - Pediatric

Year in School _____ Name of School _____

If not in school yet, where are you during the day (daycare, home, etc.)? _____

Have you missed any school this year due to illness? YES NO N/A If so how many days _____

Do you have any of the following? (circle) ☐ No Barriers

glasses / contacts poor hearing language barrier religious/cultural barrier

Have you received all routine immunizations (for your age)? YES NO

Have you received a flu shot this year? YES NO

Have you received an adult pneumonia shot in the past? YES NO If so when _____

Any chemical or allergic exposures at work or school? YES NO N/A If so describe _____

Any hobbies, travel or previous work exposures? YES NO N/A If so describe _____

Have you ever used tobacco products? YES NO N/A QUIT If you quit, when _____

If yes (or quit), how many packs a day? _____

Approximate years smoking _____Cigarettes _____Cigars_____Chewing

Tobacco Do you consume alcoholic beverages? YES NO N/A

If so how many average alcoholic drinks per week _____

Have you ever used recreational drugs? YES NO N/A

If so, are you still currently using? YES NO N/A If so, type _____

Do you exercise regularly or play sports? YES NO N/A

If yes, what do you do _____

Family Medical History ☐ **Adopted** ☐ **Unknown**

Has any family member been diagnosed with any of the following? (please check)

	Mom	Dad	Children	Siblings	Other-explain
Unusual Childhood illnesses (if yes, type)					
Asthma					
Nasal or Eye Allergies					
Eczema					
Hives					
Swelling of body parts					
Diabetes					
High blood pressure					
High cholesterol					
Celiac Disease					
Food Intolerances/Sensitivities (Type)					
Emphysema or COPD					
Thyroid problems					
Migraines					
Immune problems (if yes, type)					
Unusual infections (if yes, type)					
Cancer (if yes, type)					
Heart disease before 55 years old					
Heart disease after 55 years old					
Other medical conditions (if yes, type)					

Explain any yes answers

_____

_____

_____

_____

_____

_____

_____

Environmental History for Primary Residency (If multiple, answer separately)

Who do you live with?					
Does anyone you live with smoke?	YES	NO	Who smokes?		
Any pets in the home?	YES	NO	List types & number of pets		
If yes, do the pets go in the bedroom?	YES	NO			
Do you sleep with the pets?	YES	NO			
What type of housing is it?	House	Apt	Condo	Other	
How old is your housing?					
Do you have a basement?	YES	NO			
If yes, is the basement used?	YES	NO			
The basement is	DRY	DAMP			
Has the basement ever flooded or gotten wet?	YES	NO			
What kind of heat do you have?	Gas	Oil	Propane	Other	
	Vents	Radiators	Baseboard	Other	
Do you have a fireplace?	YES	NO	Gas	Wood-burning	
If yes, is it used?	YES	NO			
Do you have air conditioning?	YES	NO	Central	Window Units	
If yes, is it used?	YES	NO			
Do you have any special air filters?	YES	NO			
If yes, where are they?					
Do you have any dehumidifiers?	YES	NO			
If yes, where are they?					
What kind of flooring do you have on most of the floors?	Hardwood	Area Rugs	w/w Carpet	Other	
What kind of flooring do you have in the bedroom?	Hardwood	Area Rugs	w/w Carpet	Other	
What kind of covering do you have on the windows?	Blinds	Shades	Curtains	Other	
Do you have any stuffed toys or collectibles?	YES	NO			
If yes, how many?	A few	Many	Too Many		
How old is your mattress?					
Any special allergy covers?	YES	NO	On the Mattress	On Pillows	
Any feather, down, or goose bedding?	YES	NO			
What kind of vacuum do you have?	Regular	HEPA	Central	Other	None
Any other living conditions (dorm room, split custody, other homes)?	YES	NO	Describe		

Name & location of local pharmacy _____

_____

Mail-away pharmacy _____

Review of Systems

Have you had any significant or recurrent problems with the following? (please check all that apply)

Constitutional	□ Weight loss	□ Weight gain	□ Fatigue	□ Temperature intolerance
	□ Fever	□ Chills	□ Loss of appetite	
Facial	□ Tenderness	□ Swelling	□ Pain	
Eyes	□ Visual Problems	□ Glasses	□ Contacts	□ Eye Pain
	□ Itchiness	□ Redness	□ Swelling	□ Dark Circles
Nasal	□ Itch	□ Sneezing	□ Congestion	□ Change in Sense of Smell
	□ Bleeding	□ Discharge	□ Sinus Infections	
Ears	□ Blockage	□ Itch	□ Pain	□ Ringing
	□ Hearing Loss	□ Infections	□ Ear Tubes	□ Ruptured Ear Drums
Oral/Throat	□ Dental Issues	□ Bad Breath	□ Change in Voice	□ Change in Sense of Taste
	□ Sore Throat	□ Thrush	□ Hoarseness	□ Snoring
	□ Post-nasal Drip		□ Frequent Strep	
Respiratory	□ Shortness of Breath	□ Cough	□ Cough with Activity or Laughter	□ Wheezing
	□ Chest Tightness	□ Cough up Blood	□ Nighttime Cough or Awakening	□ Frequent Pneumonia
	□ Frequent Bronchitis	□ Cough up Mucus	□ Colds that always go into the chest	
Cardiovascular	□ Chest Pain	□ Palpitations	□ Irregular Heartbeat	□ Exercise Intolerance
	□ Feeling Faint	□ Murmurs		
Gastrointestinal	□ Stomach Pain	□ Constipation	□ Diarrhea	□ Nausea
	□ Vomiting	□ Hepatitis		
Skin	□ Rashes	□ Sensitive Skin	□ Easy Bruising	□ Blueness of Hands or Feet
Musculoskeletal	□ Joint Pain/Swelling	□ Muscle Pain/Cramps/Weakness		□ Arthritis
Neurologic	□ Sinus Headaches	□ Migraine Headaches	□ Generalized Headaches	□ Dizziness
	□ Numbness	□ Difficulty with Balance	□ Sleep Apnea	□ Memory Problems
	□ Insomnia	□ Problems with speech		□ Vertigo
Psychiatric	□ Depression	□ Anxiety	□ Mood Disturbances	□ Psychiatric Illness
Endocrine	□ Thyroid Problems	□ Hormonal Issues		
Hematological	□ Anemia	□ Bleeding	□ Previous Blood Transfusions	
	□ Swollen Lymph Nodes	□ Jaundice	□ Low Blood Counts	

Use this space to explain any positive answers if necessary

Patient/Parent Signature _____ Date _____

Physician Signature _____ Date _____