Asthma, Allergy and Immunology Review

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Name_____ Age _____

Occupation _____

How would you like to be addressed? _____

Date _____ Referred by (if any): _____ Primary Physician _____

Antihistamine medications (see attached list) interfere with allergy skin testing. **Stop antihistamines 7 days before your appointment.** You do not need to stop other medications not listed on the attached sheet. DO NOT STOP asthma inhalers. If you are presenting for evaluation of **hives**, **you do not need to stop antihistamines**. Complete this questionnaire before you see the doctor, as this information will help your allergist evaluate and treat your medical condition. If you are the parent of a young patient, answer for your child as best as you can. Thank you.

I. Describe in your own words the reason for your visit: _____

_____

Nasal Symptoms (proceed to next section if this is not applicable to you)

1. Do you have nasal symptoms? Yes No If yes, circle all that apply:

Stuffy nose	Itchy mouth/ears	Loss of taste/smell
Runny nose	Sneezing	Itchy/red/watery eyes
Itchy nose	Snoring	Hoarseness
Nasal polyps	Throat clearing/post nasal drip	Other Symptoms: _____
Nose bleeds	Sore throat	_____

2. Are symptons year round? Yes No If no, what seasons are worse? _____
3. Do you have symptoms when exposed to the following? Circle all that apply:

Grass	Cats	Temperature changes	Eating
Trees	Dogs	Windy weather	Alcoholic beverages
Weeds	Exercise	Strong Smells	Chemicals
Molds	Dust	Smoke	Other: _____

4. Have you ever had allergy skin or blood testing? Yes No If yes, when? _____
5. Have you ever been on allergy injections? Yes No If yes, when and how long? _____
6. Have you had ear infections? Yes No If yes, how often? _____
7. Have you had sinus infections in the past? Yes No If yes, how often? _____
8. Have you had pneumonia? Yes No If yes, when? _____
9. Have you had an x-ray or CT scan of your sinuses? Yes No If yes, when? _____
10. What medications (including nose sprays) have you used for this: _____

_____

Respiratory Symptoms (proceed to next section if this is not applicable to you)

1. Circle symptoms currently present:

Shortness of breath at rest	Cough	Night time awakenings due to respiratory symptoms
Shortness of breath with activity	Chest tightness	Other symptoms?: _____
Wheezing	Phlegm	_____

2. History of RSV? Yes No History of bronchiolitis? Yes No History of Croup? Yes No
3. Do you have asthma? Yes No If yes, year it was diagnosed _____
4. What worsens your symptoms (i.e. cold air, smoke, allergies)? _____
5. What time of the year do your symptoms worsen? _____
6. How many times a year do you have asthma exacerbations? _____
7. How many nights a week / a month do you have symptoms? _____

8. How often do you use your rescue inhaler: _____ Have you ever been intubated for asthma? _____
9. Number of ER visits due to asthma _____ Number of hospitalizations due to asthma _____
10. How many missed school or work days in the past year for allergies and/or asthma? _____
11. How many times have you needed steroids (pills or injections) for asthma exacerbations in the past year? _____
12. Date of last steroid taken (oral or injection): _____
13. Have you had a chest x-ray or CT of your chest? Yes No When? _____
14. What medications have you used for this: _____

Rash or Eczema (proceed to next section if this is not applicable to you)

1. Do you have eczema? Yes No Location of rash _____
2. How long have you had the rash? _____ What makes the rash worse? _____
3. What medicines have you used for the rash? _____
4. What soaps and lotions do you use? _____
5. Have you had a reaction to metals and/or cosmetics? _____

Hives or Swelling (proceed to next section if this is not applicable to you)

1. Do you have hives? Yes No Location of symptoms: _____ Lip or tongue swelling? Yes No
2. Describe symptoms: _____
3. How long have you had symptoms? _____ What worsens symptoms? _____
4. Do you have an Epi-pen? Yes No Have you had a skin biopsy? _____
5. What medications have you used for this: _____

Other Allergies (proceed to next section if this is not applicable to you)

1. Do you think you have a food allergy? Yes No Have you had allergy testing to foods? _____
2. If yes, to what foods and what symptoms do you have with those foods? _____

   _____

   _____
3. Have you had a serious or life threatening reaction to an insect sting? Yes No
4. What insect and describe reaction? _____
5. Do you have an Epi-pen? Yes No
6. Are you allergic to latex? Yes No What are your symptoms? _____
7. Have you had anaphylaxis or a severe allergic reaction? Explain symptoms and possible trigger: _____

   _____

II. Past Medical History

1. Have you been diagnosed with following conditions? Check if present:

___ Heart/vascular disease	___ Diabetes	___ High blood pressure
___ Recent pnuemonia	___ Cataracts	___ HIV / AIDS
___ Emphysema/COPD	___ Glaucoma	___ Cancer (type _____)
___ Recurrent otitis media	___ Reflux disease	___ Thyroid disease
	___ Recurrent sinusitis	___ Kidney disease

2. Other medical conditions: _____
3. Have you had the following surgeries? (List approximate dates)

   _____ Sinus surgery _____ Tonsillectomy _____ Adenoidectomy _____ Ear tubes
4. Other surgeries and dates: _____

   _____
5. Immunizations: Are your immunizations up to date? Yes No (Please list dates of vaccines below)

   _____ Tetanus _____ Influenza (flu) _____ Pneumonia

6. Have you had a reaction to vaccine? When and what reaction? _____

Medications

Please list medications you are currently taking, including medications you take as needed, over the counter medications, vitamins, and herbal supplements. Continue on back of the page if needed.

Medication Name Dose Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list any **medication allergies** and symptoms you experienced: _____

_____

Does aspirin cause any allergic or breathing symptoms? Yes No

III. Social History

Occupation _____ Who lives at home with you? _____

Marital Status _____ Do you have children? _____ Ages? _____

Do you exercise? _____ If yes, what type and how often? _____

Do you currently smoke? Yes No If yes, # of cigarettes per day _____ For how long? _____

Did you smoke in the past? Yes No If yes, # of cigaretts per day _____ For how long? _____

When did you quit? _____

Do other people smoke in the home or car? _____ Who? _____

Do you drink alcohol? Yes No If yes, how often? _____

Do you use illicit drugs? Yes No If yes, how often? _____

IV. Environmental History

Do you live in a house/apt/mobile home? _____ How old is your home? _____

Do you have any pets? Yes No If yes, what kind and how many? _____

Do pets live: indoor outdoors Do pets sleep in the bedroom? Yes No

What type of pillow/mattress do you use (i.e. feather, down)? _____

Do you have a fireplace? _____ Do you have a wood stove? _____

Do you have carpet in your bedroom? Yes No Is there upholstered furniture in the bedroom? Yes No

What type of air filters do you have? _____ Air conditioning: Central Window Unit

Describe your work environment? _____

How long have you lived in Kansas _____ and what town do you live in? _____

If not from Kansas, where are you originally from? _____

If a child, does the child stay in daycare? Yes No What grade is child in? _____

V. For Patients under 18

Were there any complications with the pregnancy or at birth? _____

Was birth at term or preterm? _____ If preterm, at how many weeks gestation? _____

Type of delivery _____ How many days did the child stay in hospital? _____

Breastfed? Yes No Infant formula? Yes No If yes, which type? _____

Does the child have siblings? Yes No What are their ages? _____

VI. Family History

Has anyone in your family been diagnosed with the following conditions? (please list relationship to you)

_____ Nasal Allergies _____ Asthma _____ Food Allergy

_____ Hives _____ Eczema _____ Swelling episodes (lip, tongue)

_____ Cystic fibrosis _____ Immunodeficiency (frequent infections)

Other illnesses that run in your family? _____

Any early childhood deaths in your family? Cause? _____

Father's age _____ If deceased, age of death and cause _____

Mother's age _____ If deceased, age of death and cause _____

If any siblings deceased, age of death and cause _____

VII. Review of Symptoms

Are you **currently** experiencing any of the following symptoms? (Please check all that apply)

General

___ Fever

___ Fatigue

Cardiovascular

___ Chest pain

___ Palpitations

___ Leg Swelling

Endocrine

___ Weight loss - how much _____

___ Weight gain - how much _____

Rheum

___ Muscle pain

___ Joint pain

___ Joint swelling

___ Chronic pain

GI

___ Abdominal pain

___ Nausea

___ Vomiting

___ Heartburn

___ Diarrhea

___ Constipation

___ Burping

___ Difficulty swallowing

Psych

___ Anxiety

___ Depression

GYN

___ Pregnant

___ Trying to conceive

GU

___ Pain with urination

___ Blood in urine

Heme

___ Easy bruising

___ Swollen lymph nodes - where?

___ Anemia

Neuro

___ Headaches

___ Seizures

Derm

___ Itching

___ Rash

Other relevant facts/Information that may be helpful to assist in your care: _____

_____

_____

Patient (or Guardian) Signature _____ Date _____