Allergy and Immunology Patient Questionnaire

St. Peter's Health

Patient Name_____ Appointment Date:_____

Date of Birth _____ Age _____ Sex _____

Preferred Phone Number _____ Email: _____

Which provider are you seeing today (please circle)?

Summer Monforte MD Danielle Redfield FNP

What medical problem/diagnosis or concern can we help you with today?

_____

Primary Care and/or Referring Physician: (this physician will receive a copy of your visit notes)

Name: _____

Address: _____

Phone Number: _____

Fax Number:_____

Preferred Pharmacy:

Name: _____

Address: _____

ALLERGIC HISTORY

Allergic nose symptoms? □ yes □ no If yes, triggers: □ animals □ indoor dust □ outdoor dust □ spring

□ summer □ fall □ winter □ all year long □ other_____

Allergic eye symptoms? □ yes □ no If yes, triggers: □ animals □ indoor dust □ outdoor dust □ spring

□ summer □ fall □ winter □ all year long □ other_____

Allergic skin symptoms? □ yes □ no If yes, please describe:_____

Allergic reaction to foods? □ yes □ no If yes, which food(s) and what was the reaction(s):

_____

_____

Allergic reactions to medications? □ yes □ no If yes, which medication(s) and what was the reaction(s):

_____

_____

_____

Latex allergy? □ yes □ no If yes, describe reaction:_____

Allergic reactions to insect stings? □ yes □ no If yes, which insect and what was the reaction:

_____

REVIEW OF SYSTEMS (Please circle any current/recent symptoms)

Constitutional: weight change (intentional/unintentional) appetite change failure to thrive

Sleep: apnea snoring restless sleep daytime fatigue

Skin: rash eczema itching redness swelling hives bruising infections warts hypo/hyperpigmentation (light or dark spots)

Eyes: watery itchy drainage swelling dark circles creases/lines under eyes contact lenses change in vision pain sensitivity to light dry eye

Ears/Nose/Throat: hoarseness sore throat poor sense of smell ear pain itchy nose runny nose nasal congestion polyps nosebleeds postnasal drip sinus congestion sinus infection (fever, facial pain, >1week symptoms) throat tightness speech difficulties stridor (noisy inhalation) difficulty inhaling thrush sneezing

Heart: chest pain leg/ankle swelling chest pressure dizziness fainting

Lungs: wheezing (noisy exhalation) chest tightness breathing problems at night (how many nights/month_____) breathing problems during the day (how many times per week_____) difficulty exhaling difficulty with exercise (shortness of breath, wheeze, stridor, cough) cough during the day cough at night frequent colds frequent bronchitis low oxygen

GI: abdominal pain bloody stools burping choking on food and drink regurgitation/spitting up gagging with food and drink trouble swallowing heartburn/acid in throat nausea vomiting constipation diarrhea food texture avoidance (soft/crunchy/bolus)

Musculoskeletal: joint problems (redness, stiffness, pain, large or small joints) fractures

Heme/Lymph: easy bleeding easy bruising poor wound healing large lymph nodes

Psychiatric: anxiety depression/tearful panic hyperactivity developmental delay stress

PREVIOUS ALLERGY/BREATHING TESTING □ none □ allergy skin testing - when? _____

□ allergy blood testing - when?_____ □ allergy shots - when? _____

□ Pulmonary function testing when?_____ □ bronchoscopy when? _____

□ asthma challenge (methacholine/exercise) when? _____

□ Chest CT when?_____ □ sinus CT when? _____

PAST MEDICAL HISTORY

Birth and Developmental History:

Born on Time? □ yes □ no □ unknown If no, how early?_____

Severe breathing problems at birth? □ yes □ no □ unknown

PEDIATRIC PATIENTS please complete remaining birth history. **Adults, please continue to vaccination history**.

Cradle cap at birth? □ yes □ no History of eczema? □ yes □ no If yes, at what age? _____

Birth Weight _____ Breast fed? □ yes □no If yes, for how long? _____

Bottle Fed? □ yes □ no If yes, which formula(s)?_____

Difficulty introducing foods? □ yes □ no If yes, please explain_____

Growth: □ normal □ rapid □ delayed

Development: □ normal □ delayed

VACCINATION HISTORY

All childhood vaccines received (up to date for age) □ yes □ unknown □ no If no, which required for catch up?

_____

Last Flu shot? _____Last Pneumonia vaccine? _____Last tetanus booster? _____

DIET HISTORY

□ unrestricted diet □ vegetarian □ vegan □ gluten-free

□ avoiding the following foods: _____

Does the patient tolerate bolus foods (meats, breads for example)? □ yes □ no

Difficulty swallowing or feeling of food or pills getting "stuck"? □ yes □ no

Diet includes normal portions of (mark all that apply):

□ milk as such (including dairy such as cheese, yogurt, ice cream) □ milk in baked goods

□ egg as such (whole eggs, mayonnaise, custards, French toast etc) □ egg in baked goods

□ wheat (breads, cereals, crackers etc) □ soy (common ingredient in many processed foods) □ peanut

□ other nuts (please circle: pecans, walnuts, almonds, cashews, pistachios, brazil, macadamia, pine, other_____)

□ seeds (sesame, sunflower, pumpkin) □ fish (which fish_____)

□ shellfish (shrimp, crab, lobster, other_____) □ mollusks (clams, scallops, mussels, oysters, other_____)

MEDICAL PROBLEMS

Allergy Related: □ Asthma □ Allergic eye symptoms □ Allergic nasal symptoms

□ Atopic dermatitis (eczema, dry itchy skin) □ Hives □ Drug allergy □ Insect sting allergy

□ Food allergy □ Heartburn/reflux □ Allergic gastrointestinal disease

Immunology related □ Ear infections (frequent) □ Pneumonia □ Sinus infections (frequent)

□ Skin infections □ Immunodeficiency □ HIV infection □ multiple miscarriages □ children who died early in life

General: □ High blood pressure □ Heart failure □ Other heart disease □ Diabetes □Thyroid disease

□ COPD/Emphysema □ Sleep Apnea □ Cystic Fibrosis □ Other lung disease

□ Kidney disease □ Liver disease □ Cancer □ Autoimmune Disease

□ Glaucoma □ Cataracts

Other patient medical problems not listed above: _____

_____

HOSPITAL AND SURGICAL HISTORY

Surgeries □none

Tonsillectomy □ yes Date_____ Adenoidectomy □ yes Date_____ Sinus surgery □ yes Date(s)_____ Ear tubes □ yes Date(s)_____

Other Surgeries:

Date_____ Type _____

Date_____ Type _____

Date_____ Type _____

Date_____ Type _____

Date_____ Type _____

Other Hospitalizations □none

Date_____ Reason _____

Date_____ Reason _____

Date_____ Reason _____

Date_____ Reason _____

Date_____ Reason _____

SOCIAL, ENVIRONMENTAL, AND EXPOSURE HISTORY

Race (different races are at risk for different diseases and complications): □ Native American □ Asian □ Black or African American □ Caucasian □ Hispanic □ Jewish (Ashkenazi) □ Jewish (Sephardic) □ Middle Eastern/Arabic □ Other_____

Marital Status (self or parents'): □ Married □ Domestic Partnership □ Divorced □ Separated □ Single □Widowed

Who lives in the home: (alone, spouse, parents, caregiver, siblings etc) _____

_____

Tobacco history or second hand smoke exposure? □ yes □ no

□ Cigarettes □ Cigar □ Pipe □ Chewing Tobacco □ E-Cigarettes □ Vaping

If yes, who (self, spouse, parent, etc) _____

If yes, quantity per day and number of years of use _____ quantity _____ years

If quit, when?_____ Other Substance _____

Currently in school? □ yes □ no If yes, where and what level_____

If school completed, highest degree attained: _____

For pediatric patients, who cares for the child during the day? _____

Current Occupation or Caregiver's Occupation: _____

Previous occupations: _____

Hobbies/activities: _____

Patient lives in: □ Apartment/Condo □ Farm □ Homeless □ House □ Mobile home □ Townhouse

How old is the building: _____ How long living there:_____Water Damage? □ yes □no

Floors (check all that apply): □ carpet □ hardwood □ tile □ linoleum □ laminate □ concrete

Type of flooring in patient's bedroom? _____

Mattress age _____ All furniture bought in Montana?_____

Basement/crawl space? □ none □ finished □ unfinished □ damp/musty

Heating system: _____ Wood fireplace/pellet stove? □ yes □ no

Humidifier? □ yes □ no

Cooling System: □ none □ central air conditioning □ window air conditioning unit □ evaporative/swamp cooler

Indoor Pets: _____

Regular exposure to outdoor animals (e.g. horses, farm animals)?_____

FAMILY MEDICAL HISTORY

Any of the following diseases in a first degree relative (parent, sibling, child)? If positive, please write which relative.

□ Asthma/Reactive airways disease □ Environmental allergies □ Atopic dermatitis (eczema, dry itchy skin)

□ Food allergy □ allergic GI disease □ Hives □ Drug allergy □ Insect sting allergy

□ Bronchitis □ Chronic cough □ Croup □ Pneumonia □ Sinus infections (frequent)

□ Ear infections (frequent) □ Skin infections □ Immunodeficiency □ HIV infection □ Fevers (frequent)

□ High blood pressure □ Heart failure □ Other heart disease □ COPD/ Emphysema □ Sleep Apnea

□ Cystic Fibrosis □ Other lung disease □ Diabetes □ Thyroid disease □ Other hormone/endocrine

□ Kidney disease □ Liver disease □ Cancer □ Glaucoma □ Cataracts □ Autoimmune Disease

Other medical problems in the family not listed above: _____

_____

_____

MEDICATIONS (please mark current or past, and circle brand if known)

Inhaled <u>as needed</u> bronchodilator: (albuterol, ProAir, Proventil, Ventolin, Maxair, levalbuterol, Xopenex)

□ current □ past How often needed? _____

Inhaled <u>long acting</u> bronchodilator alone: (formoterol, Foradil, salmeterol, Servent, Perforomist, Arcapta, Striverdi)

□ current □ past dose_____

Inhaled Steroid: (Flovent, budesonide, Pulmicort, QVAR, Alvesco, Azmacort, Aerobid, Asmanex, Arnuity, Aerospan)

□ current □ past dose_____

Combined Inhaled long acting bronchodilator/steroid: (Advair, Symbicort, Dulera, Breo, Trelogy)

□ current □ past dose_____

Inhaled anticholinergic: (ipratropium, Atrovent, tiotropium, Spiriva, Combivent, DuoNeb, Sebri, Incruse, Tudorza)

□ current □ past dose_____

Combined anticholinergic/broncodilators: (Anoro, Bevespi, Stiolto, Utibron, Trelogy)

□ current □ past dose_____

Oral Steroids: (prednisone, prednisolone, Medrol, decadron, dexamethasone, methylprednisolone, other_____)

□ current □ past dose_____

Topical steroids: (hydrocortisone, desonide, triamcinolone, mometasone, fluocinolone, other_____)

□ current □ past dose_____

Nasal Steroids: (fluticasone, Flonase, mometasone, Nasonex, triamcinolone, Nasacort, beclomethasone, QNasl, budesonide, Rhinocort , ciclesonide, Omnaris, Veramyst, other_____)

□ current □ past dose_____

Oral antihistamines: (diphenhydramine, Benadryl, loratidine, Claritin, Alavert, cetirizine, Zyrtec, fexofenadine, Allegra, levocetirizine, Xyzal, doxepin, hydroxyzine, Atarax, desloratidine, Clarinex, other_____)

□ current □ past dose_____

Nasal Antihistamines: (Astelin, azelastine, Astepro, Patanase, olopatadine, other_____)

□ current □ past dose_____

Antihistamine eye drops: (Patanol,Pazeo, Pataday, Bepreve, Alaway, Zaditor, over the counter eye itch drops, other_____)

□ current □ past dose_____

Epinephrine: □ current □ past Brand: EpiPen, AuviQ, Adrenaclick Full dose or Junior?_____

Leukotriene receptor antagonist: (montelukast, Singulair, Zyflo, zileuton, zafirlukast, Accolate, Xolair, other_____)

□ current □ past dose_____

Biologic Injections: (Xolair, Nucala, Fasenra, Dupixent, IVIG, Rituximab, Other_____)

□ current □ past dose_____

Reflux/Heartburn medications: (Tagamet, cimetadine, Zantac, ranitidine, Pepcid, famotidine, Axid, nizatidine, Prilosec, omeprazole, pantoprazole, Nexium, other_____) □current □ past Dose_____

Blood Pressure medications:

Beta Blockers: (Acebutolol , Atenolol, Betaxolol, Bisoprolol , Esmolol, Nebivolol , Metoprolol, Acebutolol, Carteolol, Penbutolol, Pindolol, Carvedilol, Labetalol, Levobunolol, Metipranolol, Nadolol, Propranolol, Sotalol, Timolol, other_____) □ current □ past dose_____

ACE Inhibitors: (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Perindopril, Quinapril, Ramipril, Zofenopril, Other_____) □ current □ past dose_____

Angiotensin Receptor Blockers: (candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan, valsartan, other_____) □ current □ past dose_____

Antibiotics (current only): Type and dose_____

Over the counter pain relievers: (acetaminophen, ibuprofen, Motrin, Tylenol, Naproxen, Aspirin, other_____)

How often used?_____

Homeopathic remedies: _____

_____

Vitamins: _____

Supplements: _____

_____

Any other medications:

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Patient Signature_____ _____ Date _____

Guardian Signature (if applicable)_____ Date _____

Physician Signature _____ Date _____