Adult Allergy and Immunology Patient Questionnaire

This paperwork must be completed and brought with you to your appointment. If it is not completely filled out, your appointment will be rescheduled.

Patient Name_____ Appointment Date _____

Date of Birth _____ Age _____ Sex _____

What is the reason for your visit today? What condition can we help you with?

_____

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

Name: _____

Address:_____

Preferred Pharmacy:

Name: _____

Address: _____

ALLERGIC HISTORY

Allergic nose symptoms? ☐ yes ☐no If yes, triggers: ☐animals ☐ndoor dust ☐outdoor dust ☐spring ☐ summer ☐fall ☐winter ☐all year long ☐other_____

Allergic eye symptoms? ☐ yes ☐no If yes, triggers: ☐animals ☐ndoor dust ☐outdoor dust ☐spring ☐ summer ☐fall ☐winter ☐all year long ☐other_____

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

Allergic reaction to foods (**hives, difficulty breathing, swelling, repetitive vomiting, anaphylaxis**)? ☐ yes ☐no

If yes, which food(s) and what was the reaction(s):

_____

_____

Allergic reactions to medications (**hives, difficulty breathing, swelling, repetitive vomiting, anaphylaxis**)? ☐ 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 (**hives, difficulty breathing, swelling, repetitive vomiting, anaphylaxis**)? ☐ 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

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

Sleep: apnea snoring restless sleep daytime fatigue

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?_____

☐ shest CT when?_____ ☐sinus CT when?_____

MEDICAL HISTORY

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

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

VACCINATION HISTORY

All childhood vaccines received?: ☐ yes ☐no ☐unknown

Last Flu shot? _____ Have you received a Pneumonia vaccine as an adult? _____

Last Tetanus booster? _____

DIET HISTORY

☐ unrestricted diet ☐vegetarian ☐vegan ☐gluten-free

☐ avoiding the following foods: _____

Do you tolerate bolus foods (meats, breads for example)? ☐ yes ☐no

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

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 ☐Eosinophilic esophagitis ☐allergic proctocolitis ☐FPIES

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 ☐ autoimmune disease

☐ Kidney disease ☐ Liver disease ☐ Cancer ☐ 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 _____

Hospitalizations ☐ none

Date_____ Reason _____

Date_____ Reason _____

Date_____ Reason _____

Date_____ Reason _____

Date_____ Reason _____

SOCIAL HISTORY

What race(s) do you identify with? (different races are at risk for different diseases and complications): ☐ Asian ☐Black or African American ☐ Caucasian ☐Hispanic ☐Jewish (Ashkenazi) ☐ Jewish (Sephardic) ☐Middle Eastern/Arabic ☐ Native American ☐Pacific Islander
Other_____

Marital Status: ☐ Married ☐Domestic Partners ☐Divorced ☐Separated ☐Single ☐Widowed

Who lives with you in your home: (alone, spouse, parents, children, caregiver, siblings etc)

_____

Nicotine/Tobacco use history? ☐ yes ☐no

Type of nicotine: ☐ cigarettes☐ ecigarettes/vaping ☐ chewing tobacco ☐cigars ☐pipe

If yes, quantity per day and years of use _____/day _____years If quit, when?_____

Other substance use or exposure (marijuana, methamphetamine, opiates etc)?_____

If currently using tobacco are you interested in help with quitting? ☐ yes ☐no

History of Secondhand Substance exposure? ☐ yes ☐no If yes, who (spouse, parent, etc)_____

EDUCATIONAL, OCCUPATIONAL AND EXPOSURE HISTORY:

Currently in school? ☐ yes ☐no If yes, where?_____

If school completed, highest degree attained: ☐ some high school ☐graduated high school ☐some college

☐ college degree ☐trade school ☐post graduate degree ☐Other

What is your current occupation?: _____

Previous occupation(s): _____

Hobbies/activities: _____

Patient lives in: ☐ Apartment/Condo ☐Farm/Ranch ☐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? ☐ 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 ☐ eosinophilic esophagitis ☐allergic proctocolitis ☐Chronic hives

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

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

☐ Heart failure ☐Other heart disease ☐COPD/ Emphysema ☐Sleep Apnea

☐ Cystic Fibrosis ☐Other lung disease ☐ autoimmune disease (rheumatoid arthritis, lupus etc)

☐ Kidney disease ☐Liver disease

Other medical problems in the family not listed above: _____

_____

_____

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

Inhaled as needed bronchodilator: (albuterol, ProAir, Proventil, Ventolin, Maxair, levalbuterol, Xopenex,

other_____) ☐ current ☐past How often needed? _____

Inhaled long acting bronchodilator alone: (formoterol, Foradil, salmeterol, Servent, Perforomist, other_____)

☐ current ☐past dose_____

Inhaled Steroid alone: (Flovent, Pulmicort, QVAR, Alvesco, Azmacort, Aerobid, Asmanex, other_____)

☐ current ☐past dose_____

Combined Inhaled bronchodilator/steroid: (Advair, Symbicort, Dulera, Breo, Air Duo, Wixella, other_____)

☐ current ☐ past dose_____

Inhaled anticholinergic: (ipratropium, Atrovent, Spiriva, Incruse, Tudorza, Seebri other_____)

☐ current ☐past dose_____

Other combined inhalers: (Anoro, Bevespi, Trelegy, Stiolto, Breztri, Utibron, DuoNeb, Combivent, other_____)

☐ current ☐past dose_____

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

☐ current ☐past dose_____

Topical medications: (hydrocortisone, desonide, triamcinolone, mometasone, fluocinolone, Betamethasone, Eucrisa, Protopic, Elidel, other_____)

☐ current ☐past dose_____

Nasal Steroids: (fluticasone, Flonase, mometasone, Nasonex, triamcinolone, Nasacort, beclomethasone, QNasl, budesonide, Rhinocort , ciclesonide, Omnaris, Veramyst, xhance 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, Pataday, Bepreve, Zaditor, Alaway, Visene, other_____)

☐ current ☐past dose_____

Epinephrine: ☐ current ☐past Brand: EpiPen AuviQ Generic

Other Asthma/Allergy meds: (montelukast, Singulair, Zyflo, zileuton, zafirlukast, Accolate, theophylline, Daliresp other_____)

☐ current ☐past dose_____

Biologic Medications: (Xolair, Dupixent, Nucala, Fasenra, cinquair, Rituximab, IVIG, 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: _____

Patient Signature_____ _____ Date _____

Provider Signature _____ Date _____