

Allergy and Immunology Patient Questionnaire



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

current past How often needed? _____

Inhaled long acting 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, Fasentra, 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 _____