

Name: _____
Date of Birth: _____
Today's Date: _____

New Patient Questionnaire

When do Nasal/Sinus/Eye Symptoms occur:

- Spring
- Summer
- Fall
- Winter
- All the time
- Morning
- Evening
- During sleep
- At work/school
- Outdoors
- Indoors

Physician's notes

Nasal/Sinus/Eye Symptoms are made worse by:

- Cats
- Dogs
- Dust
- Exercise
- Colds/infections
- Cigarette smoke
- Humidity
- Cold
- Mowing grass
- Raking leaves
- Heat
- Temperature changes
- Perfumes/scents
- Foods: _____
- Drugs: _____
- Other: _____

If you have Asthma or Cough Symptoms, do you have:

- Yes No Wheeze
- Yes No Shortness of breath
- Yes No Chest tightness
- Yes No Cough during sleep
- Yes No Productive cough with mucus
- Yes No Heartburn
- Yes No Diagnosis of asthma? Age: _____
- Yes No Symptoms as a child.
If yes, age started: _____
- Yes No Hospitalizations for asthma?
If yes, number: _____
- Yes No ER visits for asthma.
If yes, number: _____
- Yes No Did symptoms cause you to miss days of school or work in past year?
If yes, number: _____
- Yes No Have you used inhalers for symptoms?
If yes, names:

Asthma/Cough symptoms occur:

- Spring
- Summer
- Fall
- Winter
- All year
- Morning
- Afternoon
- Evening
- Nighttime
- At home
- At work/school

Asthma/cough symptoms are made worse by:

- Animals
- Dust
- Smoke
- Foods
- Infections
- Colds
- Humid air
- Exercise
- Cold air
- Drugs: _____

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Home Environment

- | | |
|---|---|
| <input type="checkbox"/> House | <input type="checkbox"/> City |
| <input type="checkbox"/> Apartment/condo | <input type="checkbox"/> Country/Woods/Lake |
| <input type="checkbox"/> Mobile home | <input type="checkbox"/> Suburb |
| <input type="checkbox"/> Cats How many? _____ | <input type="checkbox"/> Cigarette smoke |
| <input type="checkbox"/> Dogs How many? _____ | <input type="checkbox"/> Forced air heat |
| <input type="checkbox"/> Birds | <input type="checkbox"/> Wood burning stove/fireplace |
| <input type="checkbox"/> Other pets _____ | <input type="checkbox"/> Air conditioning |
| <input type="checkbox"/> Feather pillow | <input type="checkbox"/> Damp basement |
| <input type="checkbox"/> Down comforter | <input type="checkbox"/> Mold growth |
| <input type="checkbox"/> Bedroom carpet | <input type="checkbox"/> Whole house air cleaner |
| <input type="checkbox"/> Room air cleaner | |

Physician's notes

Social history

Occupation: _____
If child, primary residence is:
 One home Split between homes
Leisure activities: _____

Review of Systems *Circle all that apply*

- | | | | |
|-------------------------|---------------------|--------------------------|-----------------------|
| <i>General</i> | Weight gain | Weight loss | Changes in sleep |
| <i>Ears</i> | Fullness | Decreased hearing | Dizziness |
| <i>Nose</i> | Snoring | Change in sense of smell | Drainage |
| <i>Throat</i> | Hoarseness | Soreness | Difficulty Swallowing |
| <i>Respiratory</i> | Shortness of breath | Wheeze | Sputum |
| <i>Cardiovascular</i> | Chest pain | Swelling of ankles | Palpitations |
| <i>Gastrointestinal</i> | Nausea | Heartburn | Reflux |
| <i>Musculoskeletal</i> | Joint pain | Joint stiffness | Joint swelling |
| <i>Neurologic</i> | Seizures | Fainting | Weakness |
| <i>Psychiatric</i> | Changes in mood | Anxiety | |
| <i>Endocrine</i> | Cold intolerance | Heat intolerance | Tremor |
| <i>Hematologic</i> | Bleeding | Bruising | |
| <i>Skin</i> | Rash | Scaling | Nail changes |

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Hives

If you are concerned about hives, please answer the questions below:

Do the following symptoms happen at the same time?

- | | | |
|------------------------------|-----------------------------|-------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wheeze |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Trouble swallowing |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Throat tightness |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Abdominal cramping |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swelling of lips/eyelids/hands/feet |

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you under increased stress? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you recently taken new medications or supplements? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has the dose of your medications recently changed? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you had a recent infection? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have contact with latex? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a history of hepatitis? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you or your family history of low or high thyroid? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you or your family have a history of lupus or rheumatoid arthritis? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do any family members have hives or swelling episodes? |

Do any of the following cause hives or swelling?

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Heat | <input type="checkbox"/> Cold |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Foods |
| <input type="checkbox"/> Medicines | <input type="checkbox"/> Aspirin/Ibuprofen |
| <input type="checkbox"/> Foods | <input type="checkbox"/> Menses |

Physician's notes

Food Allergy

If you are concerned about a food allergy, please answer the questions below:

What symptoms occur after eating a specific food?

- | | |
|---|---|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Swollen throat | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Itchy throat | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other |

How much of the food is eaten for the reaction to occur? _____

How soon after eating do the symptoms occur? _____

Yes No Do you know what foods cause reaction?
If yes, specify: _____

Yes No Has the reaction required an ER visit or hospitalization?
If yes, when: _____

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New Patient Questionnaire

Insect Stings

If you are concerned about insect stings, please answer the questions below:

What symptoms occur after you are stung by an insect?

- | | |
|---|--|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Swollen throat | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Itchy throat | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Loss of consciousness |

Physician's notes

How many insects stung you right before the reaction occurred? _____

How soon after you were stung did the symptoms occur? _____

Yes No Do you know what insect (wasp, yellow jacket, hornet, honeybee) causes a reaction?

If yes, specify: _____

Yes No Has the reaction required an ER visit or hospitalization?

If yes, when: _____

Is there anything else you would like the doctor to know?

