*Office Use Only* Account Number_____

Allergy & Asthma Clinic of Maryland
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# New Patient Questionnaire

## I. Patient Information

Date: _____

Name: _____ Age: _____

Occupation (Current/Previous): _____ Email Address: _____

Where did you hear about us? _____

Referring Dr.: _____

Please list your other doctors and what conditions they treat: _____

Preferred Pharmacy: _____ Phone#_____

**Primary Reason for Visit**: _____

## II. Medical History

**Do you have a history of any of the following** (Please check all that apply)?

□ Asthma □ COPD/Emphysema □ Chronic Bronchitis □ Sleep Apnea
□ Hay Fever □ Nasal Polyps □ Migraine Headaches □ Eczema
□ Hives □ Insect Sting Allergy
□ Drug Allergy (please list) _____
□ Food Allergy (please list): _____
□ Recurrent Sinus Infections (how many per year) _____
□ High Blood Pressure □ Heart Disease □ High Cholesterol □ Diabetes
□ Glaucoma □ Cataracts □ Osteoporosis □ Cancer: _____
□Other: _____

## III. Family History

**Does anyone in your family have any of the following** (Please check all that apply)?

□ Asthma □ COPD/Emphysema □ Chronic Bronchitis □ Hay Fever
□ Nasal Polyps □ Eczema □ Hives
□ Immune problems (type): _____ □ Lupus □ Rheumatoid Arthritis

## IV. Environmental and Exposure History

Do you live in a: □ House □ Apartment □ other: _____

How old is your home? _____ Any water damage or mold? □ No □Yes (which one) _____

Does your home have the following? □ Carpet □ Ceiling Fans

Please list all pets (including birds, livestock, and any animals with which you have contact):

_____

Do you or have you ever smoked? □ Yes □No If you quit, when? _____

If yes, how many packs a day and for how many years? _____

If the patient is a child, is the child exposed to tobacco smoke? □ No □ Yes (who smokes?)_____

What are your hobbies? _____

In your work history, have you been exposed to toxic dust, chemicals or fumes? □ Yes □ No

What type? _____

Did you have any symptoms after exposure? □ No □ Yes

What were the symptoms? _____

How long were you exposed to the chemicals, dusts or fumes? _____

**V. Allergy Symptoms: (check all that apply)**

**Nasal Symptoms:**

□Congestion (Worse: □ Day □ Night □ Equal)

□ Nasal drainage (□ clear □ green/yellow □ bloody □ thick □ Day □ Night)

□ Postnasal drip □ Sneezing □ Itchy nose

Symptoms (check all that apply): □ Spring □ Summer □ Fall □Winter

Known or suspected triggers: □ Cat □ Dog □ Dust □ Grass □ Mold

Weather changes (□ Cold □ Heat □ Rain)

Medications you have tried: _____

Do you use over-the-counter nose spray? □ No □ Yes (Which one _____ For how long? _____)

Do you have nasal polyps? □ No □ Yes

**Eye Symptoms:** □ Itchy eyes □ Red eyes □Dry Eyes □ Puffy/Swollen eyes □Dark circles

**Ear Symptoms:** □ Ear itching □ Popping/congestion □ Pain

Which side is worse? □ Left □ Right □ Equal

**Throat Symptoms:** □ Throat itching □ Sore throat □ Drainage □ Hoarseness

**Skin symptoms:** □ General skin itching □ Hives (Last time? _____) □Rash

□ Dry skin □ Eczema (worst time of year? _____)

**Have ever had allergy testing?**

□ No □ Yes (When? _____ Where? _____ Results_____)

**Sleep Apnea Screen**

□ Have a diagnosis of sleep apnea □ snore □ stop breathing at night briefly

□Have headaches in the morning □ Feel sleepy during the day

**Immunization Status**

Have you had the flu shot this year? □ Yes □No

**VI. Asthma Screen/History *(Please bring ALL inhalers to your appointment)***

Have you been diagnosed with asthma? □ No □ Yes (If yes, When? _____)

Do you Cough or Wheeze? □ No □ Yes

How often do you cough or wheeze? □ 0 □ 1 □ 2 □3 or more days a week □ Month

Which of the following makes your cough worse?

□ Exercise □Laughing □ Eating □ Laying down/night

If you have a rescue inhaler/nebulizer (Albuterol, Xopenex), you use it on average:

□ 0 □ 1 □ 2 □3 or more days a □ week □ month □Daily (_____ times a day)

If you have asthma, How many times have you:

Needed to go to the emergency room in the past year for asthma? _____

Taken oral steroids (prednisone) in the past year? _____

Been hospitalized for asthma? _____

Known or suspected triggers for asthma attacks: □ Cat □ Dog □ Dust □ Grass □ Mold

□ Exercise □ Sinus infections □ Weather changes (□ Cold □ Heat □ Rain)

## VII. Immunology Screen

Do you feel that you have frequent or recurrent infections? □ No □ Yes

Types of frequent infections (and # per year) □ Sinus Infections (# ____) □ Colds (# ____)

□ Bronchitis (# _____) □ Ear Infections (# _____) □Skin Infections (# _____)

□ Pneumonia (# _____)

Do you have a family history of immune deficiency? □ No□ Yes (If yes, what Type? _____)

## VIII. Food Sensitivities

Do you have any food sensitivities? □ No □ Yes

Which foods have caused problems? _____

What is your reaction to these foods? □ nausea □ abdominal pain □ diarrhea □ hives

□ rash □ anaphylaxis □ wheeze/asthma □ swelling

How long after you eat the food does it take for the symptoms to start? _____

Are your food reactions associated with exercising after you eat? □ No □ Yes

Please describe the association between food and exercise? _____

Does your mouth itch after eating certain fruits or vegetables? □ No □ Yes (which ones: _____)

## IX. Insect Sensitivity

Have you had a **severe** reaction to an insect bite (hives, wheezing, face or throat swelling, low blood pressure, not just local swelling) □ No □ Yes

If Yes, which insect was it (check all that applies)? □ Honeybee □ Wasp □ Yellow Jacket

□ Hornet □ Bumble Bee □Unknown

## X. Medication Sensitivities

Do you have sensitivity to any medications? □ No □ Yes (Which ones: _____) When? _____

What type of reaction you had? □ Hives □ Rash □ Anaphylaxis □ Wheezing/asthma

□ Swelling □ Nausea/vomiting □ abdominal pain □ Diarrhea □ other: _____

******Please don't forget to bring a list of your medications with you!!!******