Advanced Allergy & Asthma Care, PLLC.
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Board Certified in Allergy Asthma and Immunology

PATIENT QUESTIONAIRE: PLEASE REMEMBER TO SIGN AT BOTTOM OF PAGE 2!!!

Patient Name: _____ Date of Birth: _____Age_____ Sex_____

How did you hear about us: _____ Primary Doctor: _____

1. **Briefly describe the reason for your visit and what you hope to accomplish:**_____

_____

2. SYMPTOMS:

Nose:	Runny nose	Sneezing	Itching	Stuffy nose	Sniffing
	Nosebleeds	Mouth Breathing	Snoring	Loss of smell or taste	
Throat:	Postnasal drip	Sore throats	Throat clearing	Hoarseness	Itching
Sinus:	Headaches	Bad breath	Sinus infections	Frequent colds	Pressure
Ear:	Fullness	Pain	Itching	Hearing loss	Ear Infections
Eyes:	Redness	Itching	Watering	Puffiness	Discharge
Skin:	Rash	Hives	Eczema	Itching	Dryness
Chest:	Coughing	Wheezing	Tightness	Shortness of Breath	Bronchitis

Other:_____**How long have you had these symptoms?**_____

Have you missed any time from work/school because of your allergies? Yes / No If so, how many days in the last 12 months?_____

3. SYMPTOMS AFFECTED BY:

Location: Indoor Outdoor Home Office Vacation **Time of Day**: Morning Afternoon Evening Night All the Time

Seasons: Spring Summer Fall Winter All Year **Weather**: Hot Cold Dry Humid Change in Weatherhy

Allergens: House dust Cat dander Dog dander Pollen Cut grass Mold/Mildew

Irritants: Perfumes Cleaners Cigarette Smoke Paint Cooking Chemical odors

Other factors: Exercise Medication Insect Sting Foods / Food Additives Cosmetics Laughing Stress Infections Menstrual Cycle

4. What MEDICATIONS have you tried for this condition? (circle all that apply)

Prescription nose sprays: Flonase(fluticasone), Nasonex, Rhinocort, Omnaris, Qnasl, Zetonna, Astelin, Dymista, Astepro.

OTC Nose sprays: Nasocort, Cromolyn, Afrin (oxymetazoline), Nasal saline, Flonase, Nasocort AQ.

Antihistamines: Claritin(loratidine), Zyrtec(cetirizine), Allegra(fexofenadine), Benadryl(diphenhydramine), Atarax(hydroxyzine), Xyzal.

Quick relief inhalers: ProAir, Ventolin, Proventil, Xopenex, Albuterol nebulized solution.

Daily Asthma inhalers: Flovent 44 /110/ 220 mcg, Pulmicort 90/180 mcg, Qvar 40/80 mcg, Asmanex 110/220 mcg, Alvesco 80/160mcg, Aerospan, Advair green/yellow/red, Symbicort 80/160mcg, Dulera 100/200 mcg, Spiriva, Brovana, Anoro Ellipta.

Have you ever been prescribed oral steroids (Prednisone, Prednisolone, Medrol)? If YES, when and why?_____

Which of the above circled meds helped? If they did not help or could not tolerate, place an "X" through the med. _____

5. MEDICAL HISTORY: (list all medical problems) **Hospitalizations/ER and Surgeries**:

_____

_____

_____

_____

Besides your primary care physician, what other doctors do you routinely see (list name, specialty and ph #)?

_____

6. CURRENT MEDICATIONS: You may attach list if you have one. Do not forget to list ALL OTC, topicals, eye drops, etc!

_____

_____

_____

_____

If you have **ECZEMA**, what Soap_____Lotion_____Topical steroids: mometasone, triamcinalone, fluocinolone oil, clobetasol, hydrocortisone, desonide, westcort, beclomethasone, other_____

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7. SOCIAL HISTORY: Do you have **exposure** to PETS? **Circle: DOG / CAT / BIRD** _____ INDOOR / OUTDOOR For how long_____

Where were you born?_____Raised?_____When did you move to Florida?_____

Have you ever smoked? Yes /No If yes, how many years?_____ Still smoke?_____Quit?_____

Do any household members smoke?_____If so, Inside or In the Car?_____

(THESE SECTIONS ONLY FOR ADULTS)

8. SOCIAL HISTORY:

Are you married_____single_____divorced_____How many children do you have?_____Their ages:_____

Do you drink alcohol? Yes /No How often:_____Do you use any illicit drugs? Yes /No If yes, specify_____

EMPLOYMENT HISTORY: What is your occupation?_____Current Employer?_____Since_____

Are you exposed to chemicals or smoking at work?_____Are your symptoms worse at work? Yes / No If yes, specify_____

9. FAMILY HISTORY:

Do any direct family members (siblings, parents, grandparents, children) have a history of allergy? If yes, list relatives and their ages:

Asthma_____

Allergic rhinitis_____

Eczema_____

Food Allergies _____

Autoimmune Disease_____ImmuneDeficiency_____Angioedema_____Mastocytosis_____Anaphylaxis_____

10. BIRTH HISTORY: (THIS SECTION ONLY FOR CHILDREN <18 years old):

Born Full Term / Pre – Term ? How many weeks Pre –Term?_____ Complications at birth?_____Breast Fed?_____

Immunizations Up To Date? Y / N Development Normal? Y / N Growth Normal ? Y / N Daycare ? Y / N _____

11. ENVIRONMENTAL HISTORY: Do you live in a / an: House_____Apartment_____Condo_____ Mobile home_____

Is it located on near: The water_____ Age of house: _____ How long you have been living there?_____

Is there any mildew?_____cockroaches?_____ Type of Air conditioning: Central, Window, etc._____

Type of filters: Regular, HEPA, etc._____ Type of flooring: (carpet, wood, tile, vinyl, etc.)_____Age of carpet?_____

Is carpet throughout_____ In bed rooms_____in living room_____

How old is your mattress?_____ Is your mattress: foam_____encased in plastic_____waterbed_____other____

How old is your pillow? _____Is your pillow: feather____encased in plastic____synthetic (Dacron)_____ foam_____other_____

12. ALLERGIC HISTORY: Are there any foods that you cannot eat for any reason except for taste? If so, which and Why?

_____

Are there any medications that you cannot tolerate?_____

If so, Which and Why?_____

Have you ever had a reaction to X-ray dye?_____Have you ever had a reaction to latex products (i.e. glove, balloon, etc)?_____

Have you ever had a serious allergic reaction (shortness of breath, wheezing, hives, dizziness and fainting etc.) after an insect sting? (wasp, honey bee, yellow jacket, fire ant, etc.). If so, please specify_____

PREVIOUS ALLERGY EVALUATION AND TREATMENT:

Have you ever had allergy skin testing? Yes / No If Yes, date: _____ Physician's Name:_____

What did the skin testing show?_____

Have you ever received allergy injections? Yes/ No If yes, dates:_____Did your symptoms improve with allergy injections? Yes / No

Have you ever had an adverse reaction to an allergy injection? Yes /No_____

_____ _____ _____

Signature of Patient/Parent/Guardian Name of Patient/Parent/Guardian (PRINT) Date