



**NEW PATIENT QUESTIONNAIRE: REMEMBER TO SIGN AT BOTTOM OF PAGE 2!!!**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Referred By: \_\_\_\_\_ 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 Weatherly  
**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:** Nasonex, Qnasl, Astelin(azelastine), Dymista, Astepro, Atrovent(ipratropium bromide).  
**OTC Nose sprays:** Flonase(fluticasone), Rhinocort, Nasacort, Cromolyn, Afrin (oxymetazoline), Nasal saline.  
**Antihistamines:** Claritin (loratidine), Zyrtec (cetirizine), Allegra (fexofenadine), Benadryl (diphenhydramine), Atarax (hydroxyzine).  
**Quick relief inhalers:** Albuterol, 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, Wixela/Advair 100/250/500, Symbicort 80/160mcg, Dulera 100/200 mcg, Breo 100/200, Trelegy 100/200, Breztri, Spiriva 1.25/2.5, Incruse 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 \_\_\_\_\_ Cream/Lotion \_\_\_\_\_ Topical steroids: mometasone, triamcinalone, fluocinolone oil, clobetasol, hydrocortisone, desonide, westcort, beclomethasone, fluocinonide, other \_\_\_\_\_



**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, specify \_\_\_\_\_

**(SECTION 8 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 \_\_\_\_\_

\*\*NOTE if you have had allergy skin testing previously, your insurance may not cover it again, subject to your benefits.

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