DEARBORN ALLERGY & ASTHMA CLINIC, P.C.

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NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

Parent's name (if child) _____
PRIMARY CARE PHYSICIAN _____
PHYSICIAN'S ADDRESS & PHONE: _____
_____

Please circle ONLY symptoms that bother you (patient):

Chest	**Nose**	**Sinus**	**GI**
Coughing	Nasal congestion	Sinus pain/pressure	Heartburn
Wheezing	Runny nose	Recurrent sinus infections	Belching
Shortness of breath	Sneezing	Yellow/green drainage nose	Trouble swallowing
Problems breathing	Postnasal drainage	Nasal or sinus surgery	Vomiting
__ with exercise/activity	Itchy nose		
__ at night	Loss of taste or smell		

Eyes	**Ears**	**Skin**	**Other Allergies**
Itchy eyes	Ear congestion	Itchy Skin	Reaction to medicine
Watery eyes	Ear blockage	Eczema	Reaction to food
Swelling of eyelids	Hearing loss	Hives/welting	Reaction to insects
Redness of the eyes	Recurrent infections	Swelling	Reaction to contrast media
	Popping or clicking	Rash	Reaction to latex

1. How long have symptoms been present? _____
2. How severe are your symptoms? (circle) Mild Moderate Severe
3. What time of year are your symptoms worse? (circle) Spring Summer Fall Winter All year
4. Are your symptoms worse around? (circle) Grass Weeds Leaves Hay/Barns Dust Cats Dogs Other animals Birds Mold Feather pillows Tobacco smoke Perfumes/Strong Odors Weather changes Temperature changes Spicy foods Exercise
5. What medications have been tried? _____

_____

Circle ONLY symptoms currently bothering you.

General: weight loss recurrent fevers or chills change in appetite fatigue

Eyes: itchy watery redness cataract glaucoma glasses contacts

Ears: hearing problems ringing in ears recurrent infections or discharge

Nose: nasal congestion sneezing runny nose nose bleeds postnasal drainage snoring daytime sleepiness not feeling rested in morning restless sleep

Sinus: sinus pain/pressure recurrent sinus infections discolored mucous from nose

Throat: hoarseness itchy throat lump feeling sore throats

Mouth: bleeding gums itchy tongue sores in mouth

Heart: palpitations mitral valve prolapsed high blood pressure murmurs chest pains swelling of lower legs

Lungs: shortness of breath wheezing coughing production of phlegm blood in mucous emphysema bronchitis recurrent infections shortness of breath at night sleeping on more than one pillow. Last chest X-Ray: _____

Stomach/Intestines: heartburn nausea vomiting belching stomach aches diarrhea gas/bloating constipation

Urinary Tract: frequency blood in urine pain on urination frequent infections

Reproductive: Number of pregnancies _____
Number of deliveries _____ Last menstrual period _____
Are symptoms associated with periods? _____
Method of contraception _____

Bones/Muscles: osteoporosis joint pain stiffness arthritis gout

Skin/Breast: rashes dryness itching hives swelling eczema breast lumps breast cancer

Neurologic: tingling numbness fainting headaches seizures stroke meningitis

Psychiatric: anxiety disorder depression stress nervousness insomnia panic attacks hyperventilation
Other _____

Endocrine: thyroid problems diabetes excessive thirst heat or cold intolerance

Blood: anemia easy bruising bleeding transfusions

Infection: Hepatitis A Hepatitis B Hepatitis C HIV/AIDS recurrent infections of: Skin Eyes Dental Urinary tract
Enlarge lymph nodes Sexually transmitted diseases Last TB test date _____ results: Negative / Positive

List all medical problems, surgeries, hospitalizations

_____
_____
_____
_____
_____
_____

Have you received standard immunizations with vaccines such as: measles, mumps, and/or tetanus? Yes / No
Any reactions to immunizations? _____

Family History: Please check

	Asthma	**Hay fever**	**Hives/Swelling**	**Sinus problems**	**Other**
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Siblings	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____

Social History: (circle)

Martial status: Married Single Divorced Widow
Occupation: _____
Exposure to: Chemicals Mold Dust

Smoking history: Current _____ packs/day for _____ years
Past _____ packs/day for _____ years
How long ago did you quit? _____
Alcohol use: _____ Recreational drug use: _____
Hobbies: _____

Allergy Survey: (circle or fill in answer)
Do you live in a: House / Apartment Age of home/apt: _____ length of occupancy: _____
City located: _____ Basement: Yes / No Is it: Dry Damp Water problems
Heat: Forced air Gravity Steam heat Do you have: Humidifier Dehumidifier
Air conditioning: Central Window Do you have an air cleaner: Yes / No

Bedroom: (circle)
Pillow: Feather Other Synthetic materials
Comforter: Feather Other Synthetic materials
Mattress: Feather Other Synthetic materials
Dust covers: Yes / No

Pets:

Do you have a:

Cat: Yes / No How long? _____ Do you have symptoms around them? Yes / No

Dog: Yes / No How long? _____ Do you have symptoms around them? Yes / No

What other type of animals do you have? _____ How long? _____ Do you have symptoms around them? Yes / No

Any smokers in the family that live with you? Who? _____

List all foods/beverages you suspect cause an allergic reaction _____
_____

What medications are you allergic to? List medications and the reactions you have had to them.
If you have had a reaction to a stinging insect (bee, wasp, hornet, fire ants), please describe reaction.

_____
_____

Do you have problems with rubber (latex) gloves, balloons, rubber bands or other rubber products/pacifier? Yes / No
If you have had a reaction to latex, please describe:

_____

If you have had a reaction to contrast media, please describe:

_____
_____

Have you ever had allergy skin test and/or treatment by an allergist? Yes / No
When? _____ Dr. _____
Have you received allergy injections? Yes / No from_____ to _____ last shot _____.
Do you feel allergy injections helped? Yes / No / Some

What doctor recommended you for consultation here? Please give name, specialty and address:

_____

Reviewed date: _____

Diane L. Baranowski, MD _____

Sonia L. Joychan, MD _____