ASTHMA *and* ALLERGY INSTITUTE

Health Questionnaire

Welcome!
We are glad you have chosen The Asthma & Allergy Institute.

The Asthma & Allergy Institute is pleased to provide this self-directed form which will greatly increase the speed in which you are seen, while providing a comprehensive overview of your current health status (or that of your child). We look forward to **caring for you** today.

PATIENT INFORMATION

Is this form being completed by the patient ☐ or a parent ☐ or guardian ☐ ? (Check one

Today's Date: ________________

Name:____

Age:_________ **Date of Birth:** __________________

Have you been seen in this office in the last three years? ☐ Yes ☐ No

When?___________________________________

PRIMARY PROBLEM: What is the main medical problem that prompted your office visit today? Please include details to increase our understanding of your health needs.

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DURATION: How long has this problem existed: (please circle correct response)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16-20 >20

days weeks months years

SEVERITY: In your estimation, how severe are these symptoms?
(very mild) ⟶ (severe) **1 2 3 4 5**

SEASON: During which seasons of the year are your symptoms worse?

☐ year round ☐ spring ☐ summer ☐ fall ☐ winter

Care Providers Comments:

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PLACE **Where are symptoms noted more?**

❑ no particular place ❑ outside ❑ inside ❑ at home ❑ at work
❑ at school ❑ when shopping ❑ at church ❑ at a relative's home (indicate) _____
❑ other (please specify) _____

TIME **When are symptoms worse?**

❑ during the daytime ❑ in the morning ❑ in the afternoon ❑ during the nighttime
❑ during the weekday ❑ during the weekend ❑ other(please indicate) _____

AGGRAVATING FACTORS **What factors worsen symptoms?**

Allergens			Pollen
	❑ dust	❑ mold	❑ grass
	❑ birds	❑ cats	❑ tree
	❑ rabbits	❑ dogs	❑ weed
	❑ hamsters/guinea pigs		Symptoms Worsen
Irritants	❑ smoke	❑ perfume	(check months)
	❑ detergents	❑ strong chemicals	❑ January
	❑ soaps	❑ others _____	❑ February
Weather	❑ cold	❑ heat	❑ March
	❑ rain	❑ fog	❑ April
	❑ dry conditions	❑ windy conditions	❑ May
	❑ low humidity	❑ high humidity	❑ June
	❑ cloudy conditions	❑ changing temperatures	❑ July
Activities	❑ daily activities	❑ strenuous activities	❑ August
	❑ walking short distances	❑ walking quickly	❑ September
	❑ running	❑ walking up stairs	❑ October
	❑ running long distances	❑ playing	❑ November
	❑ other		❑ December

AMELIORATING FACTORS **What factors improve symptoms?** (please check all that apply)

❑ avoiding exercise ❑ staying inside ❑ staying outside ❑ keeping temperatures steady
❑ avoiding troublesome exposures ❑ medicine
❑ other (please indicate) _
_____

CURRENT ALLERGY MEDICATIONS **Medicines currently being used to control allergy symptoms? ❑ N ❑ Y**

Allergy Medicine	**Frequency**	**Effectiveness**
1. _____	_____	(not) 1 2 3 4 5 (very)
2. _____	_____	(not) 1 2 3 4 5 (very)
3. _____	_____	(not) 1 2 3 4 5 (very)
4._____	_____	(not) 1 2 3 4 5 (very)

PREVIOUS ALLERGY HISTORY **Is there a history of previous allergy treatments?** **❑ NO ❑ YES**

Have you seen other physicians for your allergy symptoms?

❑ Yes ❑ No When _____

Treatments:	**Benefit:**			
❑ prescription medications	❑ none	❑ some	❑ good	❑ very good
❑ otc medications	❑ none	❑ some	❑ good	❑ very good
❑ allergy shots	❑ none	❑ some	❑ good	❑ very good
❑ avoidance measures	❑ none	❑ some	❑ good	❑ very good

How effective was previous allergy treatment?

❑ not effective at all ❑ not very effective
❑ effective ❑ very effective

Care Providers Comments:

SENSITIVITY HISTORY **Are you aware of any specific sensitivities?**
❑ **NO** ❑ **YES** (Please indicate)

CONTACT SENSITIVITY

❑ poison ivy ❑ nickel ❑ gold
❑ silver ❑ rubber/latex ❑ leather
❑ plants ❑ chemicals ❑ other materials/fabrics
❑ other

STINGING INSECT SENSITIVITY ❑ bee sting ❑ fire ant ❑ other _____

Care Providers Comments:

FAMILY HISTORY **Is there a family history of previous allergies / allergy treatment?** ❑ **NO** ❑ **YES**

❑ Asthma	❑ mother	❑ father	❑ brothers/sisters	❑ grandmothers	❑ grandfathers	❑ aunts	❑ uncles
❑ Rhinitis (Hay fever)	❑ mother	❑ father	❑ brothers/sisters	❑ grandmothers	❑ grandfathers	❑ aunts	❑ uncles
❑ Skin allergy	❑ mother	❑ father	❑ brothers/sisters	❑ grandmothers	❑ grandfathers	❑ aunts	❑ uncles
❑ Food allergy	❑ mother	❑ father	❑ brothers/sisters	❑ grandmothers	❑ grandfathers	❑ aunts	❑ uncles
❑ Ear infections	❑ mother	❑ father	❑ brothers/sisters	❑ grandmothers	❑ grandfathers	❑ aunts	❑ uncles

❑ Other (please specify) _____

ENVIRONMENTAL HISTORY

Do you live in ❑ a house ❑ an apartment ❑ trailer ❑ other _____
Where is home located? ❑ rural area ❑ urban/city area ❑ near factory/industry
❑ near ocean/lake/river
How old is home? _____ How long lived in home? _____
Is there any water damage or leakage in home? ❑ **NO** ❑ **YES**
Type of heating (check one)? ❑ forced air ❑ gas ❑ radiant ❑ electric
❑ wood burning ❑ other
Do you have air conditioning? ❑ **NO** ❑ **YES** **If YES,** ❑ window unit ❑ central
Do you have a fireplace? ❑ **NO** ❑ **YES** **If YES, how often is it used? _____**
Check which rooms have carpeting: ❑ bedrooms ❑ tv rooms ❑ living room
❑ other
Type of pillow or comforter used? ❑ feather ❑ poly fill ❑ cotton fill
❑ other _____
Do you have a pillow/mattress dust-proof encasements? ❑ **NO** ❑ **YES**
Do you have any pets? ❑ **NO** ❑ **YES** **Specify type(s) _____**
If you have pets, where do they sleep? _____
Does anyone in your home smoke? ❑ **NO** ❑ **YES**
Is your child's daytime caregiver? ❑ home ❑ daycare ❑ school ❑ other _____

Care Providers Comments:

SOCIAL HISTORY

Do you smoke? ❑ **NO** ❑ **YES** **If YES, what tobacco products?**
❑ cigarettes ❑ cigars ❑ pipe How long have you smoked? _____

Do you drink? ❑ **NO** ❑ **YES** **If YES, please indicated which kinds?**
❑ beer ❑ wine ❑ mixed drinks
How often do you drink? ❑ daily ❑ on weekends ❑ socially

SERIOUS MEDICAL PROBLEMS **Is there a history of any serous medical problems?** ❑ **NO** ❑ **YES**

(please check all that apply)

❑ diabetes controlled with insulin ❑ diabetes controlled with oral medication
❑ diabetes controlled with diet ❑ high blood pressure
❑ skipped heart beats ❑ angina or heart pain
❑ previous heart attack ❑ heart failure
❑ mitral valve prolapsed ❑ stroke
❑ hyperthyroidism ❑ hypothyroidism
❑ other heart conditions (please specify) _____
❑ fainting (indicate why) _____
❑ seizures or epilepsy (type, if known) _____

PREVIOUS ADRENALIN USE **Is there a history of previous use of Adrenalin / Epinephrine?** ❑ **No** ❑ **Yes**

PAST MEDICAL HISTORY (List all in order of most recent first.)

Is there a history of previous hospitalization(s)? ❑ **NO** ❑ **YES**
(Please indicate reasons and approximate dates)

1. date _____
2. date _____
3. date _____

Is there a history of previous surgery? ❑ **NO** ❑ **YES**

1. date _____
2. date _____
3. date _____

Is there a history of previous emergency room visits? ❑ **NO** ❑ **YES**

1. date _____
2. date _____
3. date _____

Is there a history of previous drug sensitivity? ❑ **NO** ❑ **YES**

1. date _____
2. date _____
3. date _____

COLLATERAL ALLERGY

Is there a history of additional allergy symptoms? ❑ **NO** ❑ **YES**

*In the past, have you suffered from conditions …… (Please check all that apply)

Involving the **head**? ❑ NO ❑ YES

❑sinus headache over the eyes ❑sinus infections
❑sinus headache behind the eyes ❑sinus headache on top of head
❑sinus headache in back of head ❑sinus headaches on sides of
❑migraine headaches ❑sinus headache in the cheeks

Involving the **eyes**? ❑ NO ❑ YES

❑ itching ❑ redness ❑ swelling
❑ tearing ❑ blurring ❑ burning
❑ dryness ❑ blinking

Involving the **ears**? ❑ NO ❑ YES

❑ recurrent ear infections ❑ tubes in ears currently ❑fluid in ears
❑ tubes in ears in past ❑ tubes in ears more than once ❑ pain in ears
❑ pulling at ears ❑ speaks loudly

Involving the **nose**? ❑ NO ❑ YES

❑ decreased sense of smell ❑ runny nose ❑ stuffy nose
❑ decreased sense of taste ❑painful nose ❑ bloody nose
❑ post-nasal drip ❑ sneezing ❑ snoring
❑ polyps

Involving the **throat**? ❑ NO ❑ YES

❑ recurrent sore throats ❑ history of throat swelling ❑throat clearing
❑ recurrent laryngitis ❑ sensation of throat closing ❑excessive mucus

Involving the **lungs**? ❑ NO ❑ YES

❑ difficulty taking deep breath ❑ shortness of breath ❑ wheezing
❑ chest tightness ❑ chest heaviness ❑ coughing
❑ breathlessness ❑ nighttime asthma ❑chest pain
❑ nighttime shortness of breath ❑ nighttime coughing ❑ sighing
❑ exercised induced asthma ❑ exercise induced short of breath ❑ asthma
❑ exercise induced coughing ❑ exercise induced breathlessness ❑ infections
❑shortness of breath with daily activities
❑ shortness of breath with strenuous activities

Involving the **gastrointestinal tract**? ❑ NO ❑ YES

❑ bloating ❑ abdominal pain ❑ stomachaches
❑ diarrhea ❑ recurrent vomiting ❑ gas
❑ bloody bowel movements ❑ constipation ❑ nausea
❑ belching

Involving the **genitourinary tract**? ❑ NO ❑ YES

❑ recurrent bladder infections ❑ painful urination ❑ other

Involving the **skin**? ❑ NO ❑ YES

❑ itching ❑ recurrent skin rashes ❑ hives
❑ excessive dryness ❑ flaking skin (eczema/psoriasis) ❑ infections

Involving the **joints**? ❑ NO ❑ YES

❑ swelling ❑ pain ❑ stiffness

Care Providers Comments:

Please list specific foods which are not tolerated and which symptoms are noticed if eaten:

Food	*Symptom(s)*

General Diet Overview

3 Favorite Foods

QUALITY OF LIFE — **How do symptoms affect the overall quality of life?**

❑ not at all ❑ mildly ❑ moderately ❑ severely

Do symptoms interfere with work ability?

❑ not at all ❑ mildly ❑ moderately ❑ severely

Do symptoms interfere with play or recreational activity?

❑ not at all ❑ mildly ❑ moderately ❑ severely

Do symptoms interfere with sleep?

❑ not at all ❑ mildly ❑ moderately ❑ severely

Do symptoms interfere with family relationships?

❑ not at all ❑ mildly ❑ moderately ❑ severely

REVIEW OF SYSTEMS — **Is there a history of any of the following illnesses affecting these systems?**

HEAD
❑ migraine headaches ❑ sinus headache
❑ tumors ❑ seizures/epilepsy ❑ head trauma
❑ NONE

EYES
❑ decreased vision ❑ cataracts
❑ contacts ❑ eye pain ❑ wear glasses
❑ glaucoma ❑ blurred vision ❑ detached retina
❑ retinal hemorrhages ❑ NONE

EARS
❑ decreased hearing in left ear ❑ decreased hearing in right ear
❑ dizziness ❑ ringing in left ear ❑ ringing in right ear
❑ hearing aid ❑ Meniere's disease ❑ NONE

NOSE
❑ history of broken nose ❑ nose bleeds
❑ NONE

THROAT
❑ recurrent strep throat ❑ ulcers
❑ recurrent tonsillitis ❑ NONE

MOUTH
❑ recurrent fever blister ❑ yeast infections
❑ cracking ❑ NONE

HEART
❑ high blood pressure ❑ history of heart attack
❑ stroke ❑ rapid heart beats ❑ mitral valve prolapsed
❑ heart surgery ❑ skipped heart beats ❑ heart failure
❑ swollen ankles ❑ inability to sleep flat in bed ❑ NONE

LUNGS
❑ emphysema ❑ shortness of breath
❑ lung cancer ❑ require portable oxygen ❑ chronic lung disease
❑ NONE

GASTROENTEROLOGY
❑ chronic constipation
❑ diarrhea ❑ constipation, along with diarrhea ❑ liver disease
❑ cirrhosis ❑ hemorrhoids ❑ rectal bleeding
❑ ulcers ❑ reflux ❑ heartburn
❑ jaundice ❑ recurrent abdominal pain ❑ diverticulitis
❑ chronic hepatitis ❑ acute hepatitis in past ❑ enlarged liver
❑ irritable bowel ❑ polyps ❑ NONE

GENITOURINARY
❑ recurrent kidney infections
❑ pain on urination ❑ recurrent bladder infections ❑ tea/cola colored urine
❑ recurrent urethritis ❑ urethral reflux ❑ kidney pain
❑ blood in urine ❑ bedwetting ❑ difficulty urinating
❑ frequent urination ❑ prostate disease ❑ recurrent yeast infections
❑ NONE

Care Providers Comments:

MUSCULOSKELETAL

❑ osteoarthritis ❑ muscle weakness ❑ rheumatoid arthritis
❑ brittle bones ❑ juvenile rheumatoid arthritis ❑ non specific arthritis
❑ joint pain ❑ NONE ❑ joint swelling

SKIN

❑ dryness ❑ skin cancer ❑ acne
❑ NONE ❑ melanoma ❑ skin rashes

ENDOCRINE

❑ hyperthyroidism ❑ menstrual irregularities ❑ hypothyroidism
❑ NONE

Care Providers Comments:

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List of All Current Medications

Name	Dosage	Daily Amount

MD ORDERS

❑ PFT
❑ PFT w/ bronchodilator
❑ ACT
❑ RSI
❑ Tympanogram
❑ Audiogram
❑ Histatrol Test
❑ Stop antihistamines 5 days prior to next ov
❑ Prick testing to inhalants
❑ Prick testing to foods
❑ Chest X-Ray PA and Lateral
❑ Lateral airway
❑ Sinus series
❑ Waters view

❑ CT of the sinuses
❑ CT of the lungs
❑ Fill out order form for CT of the sinuses
❑ Fill out order form for CT of the lungs
❑ Patch testingN Pulse oximetry
❑ Keep patch test site dry
❑ Return for follow up per protocol
❑ Obtain a diet review
❑ Keep a Diet Diary
❑ Two-day rotation diet
❑ Factory Free diet
❑ Yeast free diet
❑ Yeast reduced diet
❑ Sugar free diet

❑ Sugar reduced diet
❑ Food ledger
❑ Reduce caffeine per protocol
❑ Sugar free diet
❑ Six minute walk
❑ Pulse oximetry pre & post six minute walk
❑ Continue Miller injections
❑ Pulse oximetry
❑ Schedule OV with Dr. _____
❑ Get Dr. _____ on the line
❑ Get Mist line online: Dept of _____
❑ Schedule Next OV 1wk 2wk 4wk 3mo 6mo 1yr
❑ Telephone follow-up

LAB ORDERS

❑ Total IGE
❑ Total Eosinophil Count
❑ CBC with differential
❑ Sed Rate
❑ CRP
❑ ANA
❑ Quantitative Immunoglobulins
❑ Subclasses of IgG and IgA
❑ ASO Titer
❑ Rheumatoid Factor
❑ TPO Antibiodies
❑ Antithyroglobulin Antibodies
❑ T4, TSH
❑ C3, C4, CH50

❑ C1q
❑ H Pylori antibodies
❑ Hepatitis A, B, and C antibodies
❑ SPEP
❑ Throat Culture
❑ Skin culture of _____
❑ Urinalysis
❑ **IgE RASTS** for:
❑ Fire Ant
❑ Stinging insects
❑ Nuts
❑ Crustaceans
❑ Peanuts

❑ Milk
❑ D. Farinae
❑ D. Pteronyssinus
❑ Oak
❑ Cat
❑ Dog
❑ Bahia Grass
❑ Rye Grass
❑ Ragweed
❑ Pecan Tree
❑ Cladosporium
❑ Alternaria
❑ Latex

Additional Labs:

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