Allergy/Immunology Clinical Practice
400 Red Creek Dr., Suite 110
Rochester, NY 14623
Telephone: (585) 486-0930

Name: _____

DOB: ___/___/___ Age: ___ Sex: ___

Referring MD: _____

PCP: _____

NEW PATIENT QUESTIONNAIRE

REASON FOR YOUR VISIT TO OUR OFFICE:

Please leave this area blank.

CHEST SYMPTOMS: (CHECK HERE ___ IF NONE)

When did symptoms begin? _____

Have you ever been diagnosed with asthma? Yes No

Symptoms (circle): Cough Wheezing Chest tightness Shortness of breath

Symptoms worse (circle): At night Animals (cat/dog) Exercise Cold

Other: _____

Symptoms occur: Daily? (times/day_____) Weekly? (times/week_____)

When do your symptoms bother you the most?

All year **Spring** (Mar, Apr, May) **Summer** (Jun, Jul, Aug)
Fall (Sep, Oct, Nov) **Winter** (Dec, Jan, Feb)

How often do you use your rescue inhaler? ____times/wk

ED Vists past year ____

Hospital admissions past year? Yes No Pneumonia in past year? Yes No

EYES, EARS, NOSE, THROAT: (CHECK HERE ___ IF NONE)

When did symptoms begin? _____

Symptoms (circle): Itchiness (eyes ears nose) Runny (eyes nose) Congestion
Loss of Smell Post Nasal Drip Headache Frequent Throat Clearing
Sneezing Puffiness Raspy Voice/Hoarseness Cough
Other: _____

Symptoms worse (circle): At night Animals (cat/dog) Exercise Cold Dust
Odors Other: _____

When do your symptoms bother you the most?

All year **Spring** (Mar, Apr, May) **Summer** (Jun, Jul, Aug)
Fall (Sep, Oct, Nov) **Winter** (Dec, Jan, Feb)

Symptoms occur: Daily? (times/day_____) Weekly? (times/week_____)

Treated for sinusitis? Yes No Times in past year: _____ Polyps? Yes No

Sinus surgery? Yes No Ear infections? Yes No #_____

Tubes? Yes No Tonsillectomy? Yes No Adenoidectomy? Yes No

Name: _____

Please leave this area blank.

SKIN SYMPTOMS: (CHECK HERE ___ IF NONE)

Symptoms (circle): Hives Swelling Rash Itching Redness Burning

When did symptoms begin? _____

Symptoms worse (circle): At night Animals (cat/dog) Exercise Cold

Other: _____

Symptoms occur: Daily? (times/day_____) Weekly? (times/week_____)

When do your symptoms bother you the most?

All year **Spring** (Mar, Apr, May) **Summer** (Jun, Jul, Aug)
Fall (Sep, Oct, Nov) **Winter** (Dec, Jan, Feb)

If hives, how long do they last? _____ Do you have picture? _____

What do they look like? _____

REACTION TO STINGING INSECTS: (CHECK HERE _____ IF NONE)

Which insects (circle): Honeybee Bumblebee Sweat Bee Yellow Jacket
Yellow Hornet White (bald)-Faced Hornet Paper Wasp

What was the reaction? ___Anaphylaxis ___Hives ___ Large swelling
___ Small swelling

Explain/describe: _____

Do you carry an EpiPen? Yes No

FOOD SYMPTOMS: (CHECK HERE _____ IF NONE)

Which foods (circle): Milk Egg Wheat Soy Peanuts Tree Nuts Fish
Shellfish Other: _____

Describe symptoms: _____

_____

Time from ingestion to symptoms?
Immediate <10 min <30 min <2 hrs >2 hrs 24 hrs > 24 hrs

Any chronic symptoms? Diarrhea Blood in stool Difficulty swallowing Acid reflux

PAST MEDICAL HISTORY: Frequent infections? Yes No

_____

_____

_____

Prior Surgeries:

_____

Immunizations: Up to date? Yes No Flu shot? Yes No Pneumonia shot? Yes No

Have you ever had a reaction to any vaccination? Yes No

CURRENT MEDICATIONS: (include over-the-counter, herbal supplements, etc.)
Use back if needed

Name	Dose	When Taken

DRUG ALLERGIES/ADVERSE REACTIONS: (CHECK HERE ___ IF NONE)

Drug _____ Reaction _____

Drug _____ Reaction _____

Drug _____ Reaction _____

Have you ever had a reaction after taking aspirin or NSAIDs (ibuprofen)? Yes No

FAMILY HISTORY: (Circle all that apply)

Mother: Asthma Hay Fever Eczema Food allergy Hives Frequent infections Other_____
Father: Asthma Hay Fever Eczema Food allergy Hives Frequent infections Other_____
Siblings: Asthma Hay Fever Eczema Food allergy Hives Frequent infections Other_____

OTHER CHRONIC CONDITIONS: (CHECK HERE ___ IF NONE)
Cystic fibrosis COPD/Emphysema Autoimmune Disease

Other:_____

SOCIAL HISTORY: (Circle all that apply)

Marital status: Single Married Divorced Widow(ed)

Smoker? Yes No Date quit:_____ Packs/day:_____ Years smoked:_____

Occupation: _____

ENVIRONMENT: (Circle all that apply)

House Apartment Mobile Home Other: _____

Age of house:_____ Years in current residence:_____ Basement? Yes No
Damp? Yes No

Pets? Cat Dog Bird Hamster Rabbit Other: _____

Flooring: Carpet Hardwood Tile Linoleum

Heat/AC: Forced air Radiator Electric Gas Wood stove Central AC
Humidifier Dehumidifier Air purifier

Other information you would like us to know: _____

_____

_____

Name: _____

Please leave this area blank.

Thank you for choosing us to care for you!

UR MEDICINE
MEDICINE of THE HIGHEST ORDER