ALLERGY-ASTHMA NEW PATIENT INTAKE

Patient's Name: ______________________________ **Today's Date: _______________**
DOB: _____________

Please answer the following questions:

1. Who is filling out this form? □ Self □ Other ____________________________

2. Please list the reason for today's visit: ____

3. Do you have drug allergies?
If yes please list the medication, the nature of the reaction & how long ago:
____

4. CURRENT MEDICATIONS:
Please list your current medications:
Drug Name: _________________________ Dose: _________ Frequency: ___________
Drug Name: _________________________ Dose: _________ Frequency: ___________
Drug Name: _________________________ Dose: _________ Frequency: ___________
Drug Name: _________________________ Dose: _________ Frequency: ___________

5. Have you ever been diagnosed with asthma? □ No □ Yes If yes, when? __________

6. Do you currently have any of the following symptoms? (If no, skip to question 7)
Cough: □ No □ Yes – describe __________________________
Wheezing: □ No □ Yes – describe __________________________
Shortness of Breath: □ No □ Yes – describe __________________________
Chest Tightness: □ No □ Yes – describe __________________________

How often do you experience the above symptoms?
□ Never □ every day □ every other day □ 2x/week □ 1x/week □ 2x/month □ 1x/month

Do you wake up at night due to these symptoms?
□ Never □ every day □ every other day □ 2x/week □ 1x/week □ 2x/month □1x/month

How many puffs of rescue inhaler do you use per week? ___

Have you been hospitalized for asthma? □ No □ Yes
If yes, how many times? _____ Intensive care unit? □ No □ Yes

Have you been to an ER or taken steroids in the last year for asthma? □ No □ Yes
If yes, how many times? ______

What triggers your asthma? ______________________________

7. Do you have any nasal or sinus problems? □ **Yes** □ **No (if no, skip to question 8)**

When did they begin? ____________________

Runny nose □ No □ Yes (□ Watery □ Thick □ Clear □ Colored)

Itchy nose □ No □ Yes

Blocked nose/congestion □ No □ Yes

Frequent/repetitive sneezing □ No □ Yes

Drainage into the throat □ No □ Yes

Sinus pain/pressure □ No □ Yes (□ Cheeks □ Forehead □ Between eyes)

Nasal or sinus polyps □ No □ Yes

Loss of sense of smell □ No □ Yes

8. Do you have any eye symptoms? □ **Yes** □ **No (if no, skip to question 9)**

Itchy eyes □ No □ Yes

Red eyes □ No □ Yes

Watery eyes □ No □ Yes

Irritated eyes □ No □ Yes

9. Where are symptoms worse? □ Outdoors □ Indoors □ Home □ Work □ ______

10. Are symptoms year-round? □ No □ Yes

11. Symptoms worsen seasonally in: □ Spring □ Summer □ Fall □ Winter □ ______

12. What makes your symptoms worse? __________________________________

13. Have you ever been tested for allergies? □ **Yes** □ **No (if no, skip to question 14)**

If yes, how? □ Skin test □ Blood test When? ______________

To what was allergy detected?

□ Dust mite □ Molds □ Cockroach □ Cat □ Dog □ Feather □ Trees □ Grasses □ Weeds

Have you ever been treated with allergy shots? □ No □ Yes If yes, then?______________

14. Have you ever had eczema or dermatitis? □ **Yes** □ **No (if no, skip to question 15)**

What areas are affected? ____

What causes it to worsen? ____

15. Do you have hives/swelling? □ **Yes** □ **No (if no, skip to question 16)**

When did they begin? ____________________

How often? □ Daily □ Weekly □ Few times/month □ Monthly □ Rarely

Do you have recurrent swelling? □ No □ Yes

If yes, which body part? □ Eyelids □ Lips □ Face □ Limbs □ Trunk

Do any of the following symptoms occur in association with hives or swelling?

□ Shortness of breath □ Wheezing □ Dizzy □ Throat tightness □ Trouble swallowing

□ Abdominal cramps □ Vomiting □ Diarrhea □ Itching

Do your hives result in: □ Burning □ Pain □ Bruising □ Blood spots

Are hives aggravated/triggered by any of the following:

□ Vibration □ Pressure □ Exercise □ Heat □ Cold □ Food □ Drugs □ Sunlight

Do you suspect any causes? ____

16. Do you have headaches? □ Yes □ No (if no, skip to question 17)

Which side? □ Right □ Left □ Both

How often? □ Daily □ 2-3 times/week □ 1x/week □ 2x/month □ 1x/month □Occasionally

Are the headaches associated with any of the following?
□ Nausea □ Vomiting □ Dislike for light □ Dislike for sound □ Irritability

Have you had a Sinus CT? □ No □ Yes

Have you had nasal or sinus surgery? □ No □ Yes
If yes, when? ______________________ Who performed it? __________________________

17. Do you have any ear problems?
□ Popping □ itching □ pain □ pressure □ frequent ear infections

18. Do you have any mouth/throat problems?
□itching □sore throats □ bad breath □ mouth breathing □trouble swallowing □ hoarse voice

19. Do you have any of the following sleep problems?
□Snoring □Daytime Fatigue □Restless Sleep □Night Sweats □Morning Headaches □Stop Breathing

20. Do you have any food allergies? □ No □ Yes - describe:_____________________

21. Do you have any sensitivity to insect/bee stings? □ No □ Yes - describe: _________

22. What medicines have improved your symptoms? ____________________________________

23. What medicines have you tried without improvement? ______________________________

24. Have you experienced any side effects from any of those medicines? □ No □ Yes

If yes, describe: _________________________________

25. General Review of Systems (have you had any of the following in the past 1 month):

Fever, chills, fatigue, weight change? □ No □ Yes Describe _____________

Vision problems? □ No □ Yes Describe _____________

Frequent headaches, ear problems, hoarseness? □ No □ Yes Describe _____________

Chest pain, irregular heartbeat, fainting? □ No □ Yes Describe _____________

Abdominal pain, heartburn, gastrointestinal problems? □ No □ Yes Describe _____________

Wheezing, difficulty breathing, lung problems? □ No □ Yes Describe ____________

Seizures, dizziness, neurological problems? □ No □ Yes Describe ____________

Skin rash, hives, itchy skin? □ No □ Yes Describe____________

Joint pains, joint swelling? □ No □ Yes Describe ____________

Depression, anxiety, psychiatric problems? □ No □ Yes Describe ____________

Anemia, low iron, blood disorders? □ No □ Yes Describe ____________

Immune problems? □ No □ Yes Describe ____________

Other? Describe_________________________

26. Please list any previous medical problems: ____
____

27. Please list any previous surgeries: ____
____

28. Family History: List family members who have any of the following conditions:

- Allergies____
- Asthma____
- Eczema____
- Immune Problems____
- Other ____

29. Social History:

Please list if you consume any of the following along with amount:

□ Tobacco ____
□ Alcoholic Beverages ________________________________
□ Recreational Drugs _________________________________

- □ Marital Status:____________________________________
- □ Who do you live with? ______________________________
- □ Occupation: _______________________________________
- □ Activities/hobbies you enjoy: _______________________

30. Environmental History:

Do you have exposure to any animals? □ No □Yes -describe:_______________________

Do you have a feather or down pillow/comforter? □ No □Yes -describe: _____________

What type of flooring do you have in your house? _________________________________

Has there ever been any mold damage? □ Yes □ No

Does anyone in the household smoke? □ Yes □ No

OFFICE USE ONLY				
Vitals:				
BP:	Pulse:	Resp:	Ht:	Wt:

HPI:

EXAM:

Treatment Plan:

Physician's Signature: ______________________________ Date: ___________________