FOR OFFICE USE ONLY
PATIENT NO.

_____

ARKANSAS ALLERGY AND ASTHMA CLINIC
A TRADITION OF QUALITY PATIENT CARE SINCE 1930

PLEASE RETURN THIS FORM TO ARKANSAS ALLERGY & ASTHMA CLINIC, P.A. OR BRING IT WITH YOU TO YOUR FIRST APPOINTMENT

PATIENT QUESTIONNAIRE

DATE: ____/____/____
PATIENT NAME _____

Were you referred by a physician? ☐ Yes ☐ No If yes, by whom: _____

Were you referred by a friend or family member? ☐ Yes ☐ No If yes, by whom:_____

Other physicians you have seen in the past year for this problem:

1)_____ 2) _____

What is the **MAJOR PROBLEM** that prompted this visit (chief complaint)?

_____

_____

_____

_____

I. NASAL/HEAD SYMPTOMS:

(If you are having HEAD OR NASAL SYMPTOMS, please fill out Section I. If not, please go to the **next section**).

Itchy eyes	☐	Sinus infections	☐	Posterior nasal drainage	☐
Watery eyes	☐	Sore throat	☐	Runny nose	☐
Sneezing	☐	Ear pressure	☐	Itching of the throat	☐
Itchy nose	☐	Headache	☐	Stuffy nose	☐
Snoring	☐	Loss of smell/taste	☐		

How long have you been having these symptoms? How many years?___ months?____

What are the **TRIGGERS** that make symptoms worse? (check all that apply)

ALLERGENS	**IRRITANTS**	**WEATHER CHANGES**
☐ Mowed grass	☐ Perfumes	☐ Windy days
☐ Dead grass	☐ Soaps	☐ Cold fronts
☐ Dead leaves	☐ Detergents	☐ Temperature Changes
☐ Hay	☐ Smokes	☐ Damp weather
☐ House dust	☐ Paint	☐ Cold
☐ Cats	☐ Hair spray	☐ Heat
☐ Dogs	☐ Outside dust	☐ Time of day
☐ Feathers	☐ Cosmetics	
☐ Mold or mildew	☐ Tobacco smoke	☐ Other_____
☐ Other animals	Type_____	

Have you had previous allergy testing? ☐ Yes ☐ No _____ Year _____ M.D.

Have you ever had allergy injections? ☐ Yes ☐ No _____ # years

IIA. CHEST SYMPTOMS: *(If you are having **CHEST SYMPTOMS**, please fill out Section II. If not, please go to the **next section**).*

What are you main CHEST symptoms? (circle answers) Cough Shortness of breath Chest infections /Bronchitis Asthma/wheeze (go to IIB below)

How long has this been a problem? Number of years_____ number of months _____ Age at first episode_____

Triggers: □ When sick with colds □ Worse in the morning
□ Exercise □ Worse at night
□ Worse with seasons □ Spring □ Fall □ Summer □ Winter

Frequency: □ Daily □ ≥ 2 times/week □ ≤ 2 times/week □ Continuous _____# nights per month

What is the severity of your symptoms? (Please indicate as mild, moderate, or severe) _____.

Do these symptoms influence your level of activity? □ Yes □ No

Have you ever seen a gastroenterologist? □ Yes Date_____ Name of Dr._____
□ No City/State_____

Treatments in the past: □ Inhalers □ Steroids □ Antibiotics □ Other _____

IIB. WHEEZING/ASTHMA: (If you are having **WHEEZING OR ASTHMA**, please fill out Section IIB. If not, please go to the **next section).**

How long has asthma been a problem? Number of years____ number of months_____ Age at first episode_____

Triggers: □ Upper respiratory infections □ Exercise □ Nighttime □ Morning □ Non-seasonal
□ Worse with seasons □ Spring □ Fall □ Summer □ Winter □ Pollen exposure

Frequency: □ Daily □ ≥ 2 times/week □ ≤ 2 times/week □ Continuous _____ # nights per month

Treatments tried for wheezing:

- □ Inhalers (names)_____
- □ Nebulizers (updraft) (names) _____
- □ Steroid shots: ____ # of times _____ # in last year
- □ Steroids by mouth: _____ # of times _____ # in last year

Emergency room visits needed for asthma/wheezing? _____ Total in life _____ Total in last 12 months

Hospitalizations for Asthma: _____ Total in life _____ Total in last 12 months

Intensive Care Admissions? □ Yes □ No _____ # of times Intubation: □ Yes □ No

Was birth premature? □ Yes □ No _____ weeks early □ NICU □ Ventilator x ____ days □ O2

Had recurrent bronchitis been a problem? □ Yes □ No _____ # of times Inhalers used? □ Yes □ No

Was the first episode of wheezing associated with RSV or a viral infection? □ Yes □ No

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III. SKIN SYMPTOMS: (If you are having **SKIN SYMPTOMS**, please fill out Section III. If not, please go to the **next section**).

What are your skin symptoms?

□ Hives □ Eczema □ Itching □ Swelling (location_____) □ Rash

How long have symptoms been present? # of years_____ # of months_____ # of weeks_____

Triggers: □ Medications (name/date started taking) _____
□ Foods (name foods) _____
Frequency of reactions? □ All the time □ daily □ every few days or weeks

What symptoms occur with reactions? _____

Time after ingestion _____ Treatment _____

ER visits _____

Were you given an Epi-Pen? □ Yes □ No Have you used the Epi-Pen? □ Yes □ No

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IV. INSECT STINGS: (If you are having **GENERAL BODY REACTIONS TO INSECT STINGS**, please fill out **Section IV**. If not, please go to the **next section**).

Suspected insects:_____

Age at first reaction:_____ # of reactions**?**____

Symptoms with reaction: □ Local swelling □ Shortness of breath □ Hives (other than at sting site)

□ Wheeze □ Dizziness □ Passing out

Treatment:_____ ER visits:_____

Were you given an Epi-Pen? □ Yes □ No Have you used the Epi-Pen? □ Yes □ No

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V. RECURRENT INFECTIONS: (If you are having **FREQUENT RESPIRATORY INFECTIONS**, please fill out **Section V**. If not, please go to the **next section**).

____ Number of bouts of otitis media (ear infections) ____ in life ____ in last 12 months PE tubes □Yes □No # of sets ____

____ Number of sinusitis _____ in life _____ in last 12 months

____ Number of pneumonias _____ in life _____ in last 12 months

____ Number of skin infections _____ in life _____ in last 12 months Location(s) _____

____ Number of recurrent croup episodes _____ in life_____ in last 12 months

____ Number of hospitalizations for infections Reason(s):_____

____ Number of antibiotics in last year Name(s):_____

Have you had a previous immune workup? □ Yes Date_____ □ No

Have you had a previous ENT consultation? □ Yes Date_____ Name of ENT Dr._____

□ No City/State_____

Have you had a sinus x-ray? □ Yes Date _____ □ No

Have you had a sinus CT? □ Yes Date _____ □ No

VI. FOOD REACTIONS: (If you are having **REACTIONS TO FOODS**, please fill out **Section VI**. If not, please go to the **next section**).

Suspected food(s):_____ Age when reactions first started:_____

Number of episodes _____ Dates? _____

Frequency of reactions? □ daily □ weekly □ monthly □ Only with specific food ingestion

Symptoms of the reactions?_____

Treatment:_____ ER visits:_____

Did you have an Epi-Pen on hand? □ Yes □ No Have you used the Epi-Pen? □ Yes □ No

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VIII. MEDICATION ALLERGIES: (Medications I cannot take because of prior reactions or side effects.)

☐ NONE (No drug allergies)

DRUG/MEDICATION Describe the reaction/allergic symptoms

_____

_____

_____

IX. IMMUNIZATION HISTORY

Are your immunizations up to date?	☐ Yes	☐ No	
Tetanus booster in last ten years?	☐ Yes	☐ No	
Have you had a shingles vaccine?	☐ Yes	☐ No	Date last received_____
Pneumonia vaccine	☐ Yes	☐ No	Date last received_____
Influenza vaccine	☐ Yes	☐ No	Date last received_____

Could not receive influenza vaccine because of Egg allergy? ☐ Yes ☐ No

X. FAMILY HISTORY:

ALLERGY FAMILY HISTORY:

Is there a history of any of the following in your family?

Asthma	☐ Yes ☐ No	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother
Allergic rhinitis (hay fever)	☐ Yes ☐ No	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother
Sinus Problems	☐ Yes ☐ No	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother
Nasal Polyps	☐ Yes ☐ No	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother
Atopic Dermatitis (eczema)	☐ Yes ☐ No	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother
Hives	☐ Yes ☐ No	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother
Food Allergy	☐ Yes ☐ No	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother

GENERAL FAMILY HISTORY: In your generation or the generation before you are there any of the following?

Arthritis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Diabetes mellitus	☐ Yes	☐ No
Emphysema of the lung	☐ Yes	☐ No
Migraine	☐ Yes	☐ No

Rheumatoid arthritis	□ Yes	□ No
Lupus	□ Yes	□ No
Kidney disease	□ Yes	□ No
Seizure Disorder	□ Yes	□ No
Thyroid disease	□ Yes	□ No
Tuberculosis	□ Yes	□ No

Other diseases that are present in your family _____

SURGERIES: □ No Surgeries

Tonsillectomy	□ Yes	Date _____	□ No		
Adenoidectomy	□ Yes	Date _____	□ No		
PE tubes (ear tubes)	□ Yes	Date(s) _____	No. of times _____		□ No
Polypectomy (nasal polyp surgery)	□ Yes	Date(s) _____	No. of times _____		□ No
Septoplasty (nasal bone Repair)	□ Yes	Date _____	□ No		
Sinus Surgeries	□ Yes	Date _____	□ No		

Other surgeries: _____ Date_____

Other surgeries: _____ Date_____

X. PAST MEDICAL HISTORY:

GENERAL PERSONAL HEALTH HISTORY:

Have you ever had any of the following? (Insert the year)

Anemia	□ Yes	□ No
Cataracts	□ Yes	□ No
Chronic otitis media (ear infections)	□ Yes	□ No
Chronic sinusitis	□ Yes	□ No
Congestive heart disease (heart failure)	□ Yes	□ No
Coronary artery bypass graft	□ Yes	□ No
Coronary artery disease	□ Yes	□ No
Diabetes	□ Yes	□ No
Eczema/Dermatitis	□ Yes	□ No
Gallstones	□ Yes	□ No
GERD (reflux)	□ Yes	□ No
Glaucoma (high eye pressure)	□ Yes	□ No
Headaches	□ Yes	□ No
Heart disease	□ Yes	□ No
Hepatitis	□ Yes	□ No
Hiatal Hernia	□ Yes	□ No
Hypertension (high blood pressure)	□ Yes	□ No
Hypercholesterolemia (high cholesterol)	□ Yes	□ No
Hypoglycemia	□ Yes	□ No
Irritable bowel disease (IRB)	□ Yes	□ No
Ulcerative colitis	□ Yes	□ No
Migraine headaches	□ Yes	□ No
Mitral valve prolapse	□ Yes	□ No
Pneumonia	□ Yes	□ No
Psoriasis	□ Yes	□ No
Rheumatic heart disease	□ Yes	□ No
Seizures	□ Yes	□ No
Stroke	□ Yes	□ No
Thyroid disease	□ Yes	□ No

Cancer □ Yes □ No

Type _____

Year _____

Treatment: □ Chemotherapy

□ Radiation

□ Surgery

Tuberculosis □ Yes □ No

Other illnesses/diagnoses not listed: _____

HOSPITALIZATIONS:

Reason _____ Date_____

Reason _____ Date_____

Reason _____ Date_____

XI. OCCUPATIONAL/SOCIAL HISTORY:

City/state of residence: _____

Most recent occupation: _____

If a student, current grade in school: _____

Do you smoke or use tobacco products? □ Yes □ No
□ Cigarettes ____ packs/day _____number of years
□ Pipes
□ Cigars
□ Chewing tobacco
□ Snuff

Have you ever smoked tobacco in the past? □ Yes □ No ____ packs/day ____number of years ____ year quit

Any use of marijuana? □ Yes □ No

Alcohol use □ None □ Occasional □ Moderate □ Heavy

Workplace exposures □ Paper dust □ Chemicals □ Other _____

Types of work done in the past: _____

XI. ENVIRONMENTAL REVIEW:

Current household members: □ spouse □ children □ brothers □ sisters □ parents Total No.:_____

Age of home: □ 0-10 years □ >10 years

How long at present location? □ 0-5 years □ 6-10 years □ >10 years

Type of home: □ Apartment □ Mobile Home □ House

Heat and air details: □ Central heat/air □ Window A/C
□ Wood burning stove/fireplace □ Space heaters

Bedding details: □ Zipper encasings □ Cotton mattress/pillow □ Feather pillow
□ hypoallergenic pillow □ feather comforter □ Feather mattress

Tobacco/smoke exposure in home: □ Yes □ No
Pets/animals (inside): □ Cat □ Dog □ Other _____
Pets/animals (outside): □ Cat □ Dog □ Other _____

XII. Nutrition and Diet:

No food intolerances ☐

Food intolerances (not listed above) Food_____ Symptoms produced_____
Food_____ Symptoms produced_____

Amount of milk consumed daily: ☐ None ☐ 2-3 cups ☐ 3-5 cups

XII. TRAVEL:

☐ Symptoms improve when away from state
☐ Travel without symptoms changing

XIV. PREGNANCY AND BIRTH

Birth wt. ____lb, ____oz

Breast Fed?	☐ Yes	☐ No	How long? ___months
Hospital stay after birth?	☐ Yes	☐ No	
Numerous formula changes in the first 6-9 months of age?	☐ Yes	☐ No	
Eczema less than three months of age?	☐ Yes	☐ No	
RSV before three months of age?	☐ Yes	☐ No	

XV. PRESENT MEDICATIONS: (List here or bring a list of current medications or bring all your medications with you):

A) List all ALLERGY OR ASTHMA MEDICATIONS taken **PRESENTLY** including over-the-counter preparations, prescription tablets, oral liquids, inhalers (MDI's), nasal sprays, creams, or eye drops)

1)_____ 5) _____
2)_____ 6)_____
3)_____ 7)_____
4)_____ 8) _____

B) List all ALLERGY OR ASTHMA MEDICATIONS taken **in the PAST,** including over-the-counter preparations, prescription tablets, oral liquids, inhalers (MDI's), nasal sprays, creams, or eye drops)

1)_____ 5)_____
2)_____ 6)_____
3) _____ 7)_____
4)_____ 8)_____

C) List OTHER MEDICATIONS taken routinely or intermittently for medical reasons (i.e., vitamins, aspirin, blood pressure medications, etc)

1)_____ 5)_____
2_____) 6) _____
3)_____ 7)_____
4)_____ 8)_____

VII. SYSTEM REVIEW: Please check those symptoms you may have experienced that have NOT been mentioned above.

			Comments
GENERAL			
Appetite loss	☐ Yes	☐ No	_____
Fatigue	☐ Yes	☐ No	_____
Night sweats	☐ Yes	☐ No	_____
Weight change	☐ Yes	☐ No	_____

SKIN

Dry skin	□ Yes	□ No	_____
Change in Wart/Mole	□ Yes	□ No	_____
Hives	□ Yes	□ No	_____
Itching	□ Yes	□ No	_____
Rash	□ Yes	□ No	_____

HEENT

Dry eyes	□ Yes	□ No	_____
Glaucoma	□ Yes	□ No	_____
Glasses	□ Yes	□ No	_____
Good vision	□ Yes	□ No	_____
Posterior nasal drainage	□ Yes	□ No	_____
Clear runny nose	□ Yes	□ No	_____
Itching of soft palate	□ Yes	□ No	_____
Sneezing	□ Yes	□ No	_____
Headache	□ Yes	□ No	_____
Excessive tearing	□ Yes	□ No	_____
Hearing loss	□ Yes	□ No	_____
Ear infection	□ Yes	□ No	_____
Earache	□ Yes	□ No	_____
Ringing in ears	□ Yes	□ No	_____
Vertigo	□ Yes	□ No	_____
Nasal Congestion	□ Yes	□ No	_____
Sinus pain	□ Yes	□ No	_____
Hoarseness	□ Yes	□ No	_____
Oral ulcers	□ Yes	□ No	_____
Sore throat	□ Yes	□ No	_____
Snoring	□ Yes	□ No	_____
CPAP for Sleep Apnea	□ Yes	□ No	_____

NECK

Neck mass	□ Yes	□ No	_____
Neck pain	□ Yes	□ No	_____
Neck stiffness	□ Yes	□ No	_____
Swollen glands	□ Yes	□ No	_____

RESPIRATORY

Shortness of breath	□ Yes	□ No	_____
Chronic cough	□ Yes	□ No	_____
Decreased Exercise Tolerance	□ Yes	□ No	_____
Difficulty breathing	□ Yes	□ No	_____
Sputum production	□ Yes	□ No	_____
Wheezing	□ Yes	□ No	_____

CARDIOVASCULAR

Chest pain	□ Yes	□ No	_____
Difficulty breathing on exertion	□ Yes	□ No	_____
Fainting/blacking out	□ Yes	□ No	_____
Irregular heartbeat	□ Yes	□ No	_____
Elevated blood pressure	□ Yes	□ No	_____
Difficulty breathing lying down	□ Yes	□ No	_____
Rapid heart rate	□ Yes	□ No	_____
Swelling of extremities	□ Yes	□ No	_____

GASTROINTESTINAL

Abdominal pain	☐ Yes	☐ No	_____
Bloody stool	☐ Yes	☐ No	_____
Constipation	☐ Yes	☐ No	_____
Diarrhea	☐ Yes	☐ No	_____
Difficulty swallowing	☐ Yes	☐ No	_____
Heartburn	☐ Yes	☐ No	_____
Indigestion	☐ Yes	☐ No	_____
Nausea	☐ Yes	☐ No	_____
Vomiting	☐ Yes	☐ No	_____

MUSCULOSKELETAL

Back pain			
Joint pain	☐ Yes	☐ No	_____
Joint redness	☐ Yes	☐ No	_____
Joint swelling	☐ Yes	☐ No	_____
Muscle cramps	☐ Yes	☐ No	_____
Muscle weakness	☐ Yes	☐ No	_____

NEUROLOGICAL

Dizziness	☐ Yes	☐ No	
Fainting	☐ Yes	☐ No	_____
Headaches	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Stroke	☐ Yes	☐ No	_____
Tremor	☐ Yes	☐ No	_____

PSYCHIATRIC

Moodiness	☐ Yes	☐ No	_____
Fussiness	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____

ENDOCRINE

Appetite changes	☐ Yes	☐ No	_____
Cold intolerance	☐ Yes	☐ No	_____
Excessive thirst	☐ Yes	☐ No	_____
Excessive urination	☐ Yes	☐ No	_____
Hair changes	☐ Yes	☐ No	_____
Heat intolerance	☐ Yes	☐ No	_____
Thyroid problems	☐ Yes	☐ No	_____

HEMATOLOGY

Anemia	☐ Yes	☐ No	_____
Easy bruising	☐ Yes	☐ No	_____
Enlarged lymph nodes	☐ Yes	☐ No	_____
Nose bleeds	☐ Yes	☐ No	_____

Physician Signature:_____ Date: _____