AUSTIN REGIONAL CLINIC

Allergy-Asthma New Patient Questionnaire

Patient Name: ______________________ Date of Birth: ______________ Date: __________

Home Address: ______________________ City, State, Zip: ______________________

Home Phone Number: ______________ Work Number: ______________ Gender: ☐ Male ☐ Female

Primary Care Physician: ______________________ Referring Physician: ______________________

Insurance: ____

Information provided by this questionnaire will be of major assistance to the doctor in helping you. Please take the time to complete this questionnaire (it takes only 10-15 minutes) before your appointment. Base your answers on your own observations and not what you have been told by others or what you may have by others or what you may have presumed based on the basis of previous allergy tests.

I. Major Reason for Referral

☐ Hayfever or "sinus" ☐ Insect sting reaction
☐ Eye problems ☐ Drug reaction
☐ Asthma or chronic cough ☐ Intestinal problem
☐ Hives or swelling ☐ Food allergy
☐ Eczema or other rash ☐ Recurrent infections
☐ Headaches ☐ Other

II. Please describe in your own words the problem(s) that you are having which you think might be on a basis of an allergic reaction.

____

____

____

III. Symptom History

A. How long have you had your symptoms?

B. Are they getting worse? Yes ☐ No ☐

C. Are your symptoms (check one):

☐ Present all year but worse at certain times of the year?
☐ Coming and going without apparent relation to the time of the year?
☐ Only at certain times of the year?

D. Check the months you are worse:

☐ JAN ☐ FEB ☐ MAR ☐ APR ☐ MAY ☐ JUN
☐ JUL ☐ AUG ☐ SEP ☐ OCT ☐ NOV ☐ DEC

E. Do you have to miss school or work because of allergy symptoms?

☐ No ☐ Occasionally ☐ Frequently

F. Do your symptoms disturb your sleep?

☐ No ☐ Occasionally ☐ Frequently

G. Are you worse (check):

☐ indoors ☐ outdoors
☐ at home ☐ at work
☐ mornings ☐ evenings

H. Triggers:

☐ parks ☐ air conditioning
☐ mowed grass ☐ tobacco smoke
☐ gardening ☐ perfume
☐ weather changes ☐ pets
☐ windy days ☐ exercise
☐ humid days ☐ foods
☐ hot days ☐ soaps/detergents
☐ cold days ☐ other

I. Have you been tested for allergy previously?

Yes ☐ No ☐

J. Have you been on allergy shots before? ☐ Yes ☐ No

If yes, when, where, and for how long ______________

Were they helpful? ☐ Yes ☐ No ☐ Not sure

K. Did you have a serious reaction to allergy testing or allergy shots? ☐ Yes ☐ No

IV. Symptom Review (Check all appropriate symptoms)

A. Eye Symptoms:

☐ none ☐ itching
☐ watering ☐ redness
☐ swelling ☐ crusting
☐ dryness ☐ burning
☐ dark circles ☐ blurred vision
☐ wear contact lenses ☐ other

Allergy-Asthma New Patient Questionnaire *cont.*

IV. Symptom Review *- cont.* (Check all appropriate symptoms)

B. Ear Symptoms:

- ☐ none
- ☐ itching
- ☐ popping
- ☐ congested
- ☐ frequent infections
- ☐ fluid in middle ear
- ☐ PE tubes
- ☐ hearing loss
- ☐ earache
- ☐ dizziness
- ☐ other

C. Nasal Symptoms:

- ☐ none
- ☐ sneezing
- ☐ itching
- ☐ sniffles
- ☐ watery discharge
- ☐ cloudy discharge
- ☐ congestion
- ☐ frequent nosebleeds
- ☐ broken nose
- ☐ loss of sense of smell/taste
- ☐ polyps
- ☐ frequent sinus infections
- ☐ nasal dryness
- ☐ snoring at night
- ☐ other

D. Mouth and throat symptoms:

- ☐ none
- ☐ frequent sore throats
- ☐ hoarseness
- ☐ itchy throat
- ☐ difficulty swallowing
- ☐ swollen neck glands
- ☐ mouth breathing
- ☐ frequent strep throat
- ☐ frequent tonsillitis
- ☐ postnasal drip
- ☐ other

E. Headaches:

- ☐ infrequent
- ☐ occasional
- ☐ frequent
- ☐ occur with sinus symptoms
- ☐ Sharp
- ☐ dull
- ☐ pounding
- ☐ facial
- ☐ forehead
- ☐ temples
- ☐ back of head
- ☐ migraine
- ☐ other

F. Stomach/Intestinal symptoms:

- ☐ none
- ☐ nausea and vomiting
- ☐ bloating
- ☐ loss of appetite
- ☐ abdominal pain or cramping
- ☐ diarrhea frequently
- ☐ constipation frequently
- ☐ heartburn or indigestion
- ☐ pain, or difficulty swallowing
- ☐ other

G. Chest Symptoms:

- ☐ none
- ☐ chronic cough
- ☐ chest tightness/congestion
- ☐ sputum production
- ☐ wheezing, shortness of breath
- ☐ wheeze/cough after exercise
- ☐ chest pain or soreness

Has asthma been previously diagnosed? ☐ Yes ☐ No

Frequent pneumonias? ☐ Yes ☐ No

Abnormal chest x-ray? ☐ Yes ☐ No

H. Skin symptoms:

- ☐ none
- ☐ dry skin
- ☐ hives
- ☐ swelling
- ☐ itchy skin
- ☐ eczema
- ☐ poison ivy/oak allergy
- ☐ skin sensitivity to metals, chemicals, cosmetics
- ☐ other

I. Insect sting reaction:

- ☐ none
- ☐ large swelling
- ☐ hives
- ☐ difficulty breathing
- ☐ throat swelling
- ☐ dizzy
- ☐ other

Stung by:

- ☐ bee
- ☐ fire ant
- ☐ other

J. General Symptoms:

- ☐ fever
- ☐ appetite changes
- ☐ fatigue
- ☐ weight loss _______________lbs
- ☐ weight gain _______________lbs

K. Rheumatology

- ☐ joint pain

L. Cardiac

- ☐ heart murmur
- ☐ palpitations