MEDICAL ARTS ALLERGY, PC

ALLERGY AND CLINICAL IMMUNOLOGY QUESTIONNAIRE

Please bring the completed form with you to your appointment

PATIENT INFORMATION:

Please answer the following questions as they apply to the patient Appointment Date:

Patient Name: _____ Date of Birth: _____ Age: ____ ☐ Male ☐ Female

Referring Physician: _____ Primary Physician: _____

PURPOSE OF EVALUATION: *What is your primary concern and what do you hope to accomplish with this evaluation?*

ALLERGY HISTORY: *Please tell us about your allergy symptoms; Mark all that apply.*

Chest & Breathing Symptoms

Yes	No		Age of onset	(Please circle) Which months are your symptoms most severe?
☐	☐	Asthma		J F M A M J J A S O N D
☐	☐	Wheezing		J F M A M J J A S O N D
☐	☐	Cough		J F M A M J J A S O N D
☐	☐	Chest tightness / pain		J F M A M J J A S O N D
☐	☐	Bronchitis		J F M A M J J A S O N D

What triggers your symptoms or makes your chest & breathing symptoms worse?

What makes your chest & breathing symptoms better?

Nose & Sinus Symptoms

Yes	No		Age of onset	(Please circle) Which months are your symptoms most severe?
☐	☐	Runny nose		J F M A M J J A S O N D
☐	☐	Post-nasal drip		J F M A M J J A S O N D
☐	☐	Sneezing		J F M A M J J A S O N D
☐	☐	Congestion		J F M A M J J A S O N D
☐	☐	Sinusitis		J F M A M J J A S O N D

What triggers your symptoms or makes your nasal & sinus symptoms worse?

What makes your nasal & sinus symptoms better?

Eye Symptoms

Yes	No		Age of onset	(Please circle) Which months are your symptoms most severe?
☐	☐	Itchy / swollen eyes		J F M A M J J A S O N D
☐	☐	Irritated / burning eyes		J F M A M J J A S O N D
☐	☐	Dry eyes		J F M A M J J A S O N D
☐	☐	Teary eyes		J F M A M J J A S O N D

What triggers your symptoms or makes your eye symptoms worse?

What makes your eye symptoms better?

Skin Symptoms

Yes	No		Age of onset	(Please circle) Which months are your symptoms most severe?
☐	☐	Hives		J F M A M J J A S O N D
☐	☐	Eczema / atopic dermatitis		J F M A M J J A S O N D
☐	☐	Swollen lips / tongue		J F M A M J J A S O N D
☐	☐	Swollen face / hands / feet		J F M A M J J A S O N D

What triggers your symptoms or makes your skin symptoms worse?

What makes your skin symptoms better?

Recurrent Infections

Yes	No		Age of onset	Please provide details (date of last infection, times per year, antibiotic use)
☐	☐	Ear Infections		
☐	☐	Sinus Infections		
☐	☐	Lung Infections		
☐	☐	Skin Infections (other than acne)		

Have you experienced other severe or repeated infections? (Please provide details)

Have you required hospital treatment (overnight) for your infections? (Please provide details)

Other Allergies

Yes	No		Age of onset	Please provide details (date of reaction, symptoms…)
☐	☐	Medications		
☐	☐	Foods		
☐	☐	Insect Stings		
☐	☐	Latex		
☐	☐	Metals (such as jewelry)		
☐	☐	Soaps, Lotions, Perfumes		

Have you experienced other allergic reactions? (Please provide details)

CURRENT MEDICATIONS: *Please list medications and doses (include over-the-counter medications, vitamins and supplements).*

PREVIOUS ALLERGY EVALUATION & TREATMENT: *If possible, please provide us with copies of these records.*

Have you had **allergy skin tests** before?

☐ Yes ☐ No *If yes*, Date: _____ Physician: _____

Results: _____

Have you had **allergy blood tests (RAST**) before?

☐ Yes ☐ No *If yes*, Date: _____ Physician: _____

Results: _____

Have you received **allergy immunotherapy (allergy shots)** before?

☐ Yes ☐ No *If yes*, Date: _____ Physician: _____

Clinical Response: _____

IMMUNIZATIONS HISTORY: *(Please provide copies of vaccine records if available)*

Have you experienced any serious reaction to a vaccine? ☐ Yes ☐ No *if Yes, details:* _____

Year of your last: Flu vaccine: _____

NEWBORN HISTORY: *(If the patient is less than 18 years old)*

Was there any difficulty while the mother was pregnant with the patient? ☐ Yes ☐ No

Was the patient delivered without difficulty? ☐ Yes ☐ No

Was breathing assistance required at delivery? ☐ Yes ☐ No

Did the patient go to the regular nursery? ☐ Yes ☐ No

Did the patient require intensive care? ☐ Yes ☐ No

Feedings: Breast ☐ Yes ☐ No If yes, until age? _____

Formula ☐ Yes ☐ No If yes, until what age? _____

Solid foods were started at what age? _____

Any concerning events for the baby during birth? Please explain: _____

MEDICAL HISTORY: *Have you ever had, or do you currently have any of the following?*

	Never	Current	Past		Never	Current	Past
High or low blood pressure				Anxiety			
Coronary artery disease / angina				Migraine headaches			
Mitral valve prolapse				Sinus headaches			
Heart murmur				Tension headaches			
Stroke				Epilepsy / seizures			
Rheumatic fever				Glaucoma			
Thyroid disease				Cataracts			
Liver disease				Emphysema			
Infectious hepatitis (liver infection)				Tuberculosis			
Kidney disease				Rheumatoid arthritis			
Bladder trouble				Osteoarthritis or joint replacement			
Prostate trouble (men)				Lupus			
Stomach trouble or ulcers				Diabetes or elevated blood sugar			
Heart burn or esophageal reflux				HIV or Aids			
Depression				Cancer (please provide details)			

Do you have any other active medical problems not listed above? (Please provide details)

SURGERIES: *Please list the most recent along with reason and date.*

HOSPITALIZATIONS: *Please list the most recent along with reason and date.*

FAMILY HISTORY: *Tell us about any diseases (especially asthma, allergies, eczema…) that run in your family.*

	Age	Medical diagnoses	If deceased, at what age?
Father			
Mother			
Siblings (ages & genders)			
Children (ages & genders)			

SOCIAL HISTORY: *Please tell us about your habits and hobbies.*

Tobacco:

Do you smoke? ☐ Current ☐ Former - Year Quit _____ ☐ No, Never Does anyone you live with smoke? ☐ Yes ☐ No

Type of Cigarettes smoked: ☐ E-cigarettes/vaping ☐ Cigarettes

If you ever smoked, what was the highest number of cigarettes per day? _____, how long did you smoke? _____

If you now smoke, have you quit in the past? ☐ Yes ☐ No Are you considering quitting? ☐ Yes ☐ No

Are you regularly exposed to passive (second-hand) tobacco smoke? ☐ Yes ☐ No

Alcohol: Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week on average? _____

Hobbies: _____

Occupation / School Grade: _____

How many days have you missed from work / school because of your allergy symptoms?

If Child: Does the patient live in more than one home?

ENVIRONMENTAL SURVEY: *Please tell us about where you live and work.*

Past & Current Residences - *Please list most recent residence first*

	City, State	*Years*	*Effect on symptoms (better, worse, no change)*
1.			
2.			
3.			

What type of dwelling do you currently reside in? ☐ Single family ☐ Mobile home ☐ Town home / Condo ☐ Apartment / Dorm

How old is your current residence? _____ How long have you lived there? _____

Home construction (brick, wood…) _____ Neighborhood? ☐ urban / city ☐ rural / farm ☐ suburban

Any nearby industrial plants? _____ Any nearby agricultural operations? _____

How is your home heated? _____ How is your home cooled? _____

Carpeting: ☐ None ☐ Area rugs only ☐ Wall to wall Carpet type (synthetic, wool …) _____

Are there any damp or musty rooms? ☐ Yes ☐ No Do you have a ☐ Air Filter ☐ Dehumidifier ☐ Humidifier

How old is your pillow? _____ check details: ☐ Feather ☐ Dacron ☐ Foam ☐ Allergy-barrier encased

How old is your mattress? _____ check details: ☐ Waterbed ☐ Foam ☐ Innerspring ☐ Allergy-barrier encased

Please list any pets you own and how many. (dogs, cats, birds, horses, gerbils …)

Are your pets allowed into the bedroom? ☐ Yes ☐ No

Indoor Pets: _____

Outdoor Pets: _____

⇨ _____ _____

Signature of Patient (or patient representative) ***Date*** ***Signature of Reviewing Provider*** ***Date***

MEDICAL ARTS ALLERGY, P.C.

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Mechanicsburg, PA 17050
(717) 791-2640 Fax: (717) 791-2646

Bloom Outpatient Building
4310 Londonderry Road, Suite 201
Harrisburg, PA 17109
(717) 920-4340 Fax: (717) 920-4341

Additional Asthma Details

(Please answer as applicable to the patient)

Asthma History

Have you been in the ER because of asthma? ☐ Yes ☐ No

Details: _____

_____

Have you been hospitalized because of asthma? ☐ Yes ☐ No

Details: _____

_____

Have you been admitted to the intensive care unit because of asthma? ☐ Yes ☐ No

Details: _____

_____

Do you have a nebulizer (breathing machine) at home? ☐ Yes ☐ No

Do you have a peak flow meter at home? ☐ Yes ☐ No

Have you ever participated in an asthma education class? ☐ Yes ☐ No

Asthma Control Test

On **average**, over the past **4 weeks…**

1. How much of the time did your asthma keep you from getting as much done at work, school or at home?
☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

2. How often have you had shortness of breath?
☐ More than once a day ☐ Once a day ☐ 3-6 times a week ☐ 1-2 times a week ☐ Not at all

3. How often did your asthma symptoms wake you up at night or earlier than usual in the morning?
☐ 4 or more nights a week ☐ 2-3 nights a week ☐ Once a week ☐ Once or twice ☐ Not at all

4. How often have you used your rescue inhaler (albuterol, Maxair..) or nebulizer medication (albuterol, Xopenex…)?
☐ 3 or more times/day ☐ 1-2 times/day ☐ 2-3 times/week ☐ Once/week (or less) ☐ Not at all

5. How well would you rate your **asthma** control during the past **4 weeks**?
☐ Not controlled at all ☐ Poorly controlled ☐ Somewhat controlled ☐ Well controlled ☐ Completely controlled