Division of Allergy and Inflammation
Beth Israel Deaconess Medical Center
(617) 278-8100 ***(administrative office)***

New Patient Questionnaire

Name_____ **Age**_____ **Weight**_____ **Height**_____

Occupation_____

1. Please describe in one sentence why you are here today.

_____

2. Do you have any of the following symptoms? (Circle)

Sneezing	Blocked Nose	Watery Nose	Shortness of Breath	Hives
Wheezing	Chest Tightness	Cough	Sputum (phlegm)	Watery Eyes
Night Symptoms	Severe Itching	Severe Swelling	Acid Stomach	Rash

Age of onset? _____ How long have you had these symptoms?_____

3. Symptoms are worse during: (Circle)

Jan Feb Mar Apr May June Jul Aug Sep Oct Nov Dec No Change

Symptoms are worse: (Circle)

At Night Mornings Evenings At Home At Work Indoors Outdoors

4. Have you been told or do you think you have any of the following? (Circle)

Sinusitis	Ear Infections	Nasal Polyps	Recurrent Bronchitis	Asthma
Eczema/Rash	Hives/Swelling	Stomach Reflux	High Blood Pressure	Sleep Apnea
Diabetes	Tuberculosis	Frequent Infections	Allergic Rhinitis/Hay Fever	

Other medical conditions:_____

5. Which of the following bring on attacks of allergies or asthma? (Circle)

Air Conditioning	Drafts	Drugs	Cigarette Smoke
Cosmetics	Exercise	Fatigue	Humidity
Wool	Insecticides	Strong Odors	Alcoholic Beverages
Nervousness-Stress	Respiratory Infections	Animals: dogs / cats	Allergens: pollens / molds

Other Triggers:_____ _____ _____

6. Other Allergies?

Medications/Vaccinations:_____

Latex/Rubber Products:_____

Foods/Preservatives/Dyes:_____

Insects:(list and describe)_____

7. What are your hobbies?

Indoors?_____ Outdoors?_____

8. Family History- Has anyone in your family ever had?: (Circle and list relationship)

Asthma _____ Eczema _____

Hay Fever_____ Swelling_____

Complete Reverse Side

9. Do you have a history of prior allergy evaluation(s)? Y N When?_____

a. Skin Test Results_____

b. Previous Immunotherapy? Y N When?_____

c. Have you ever received Cortisone drugs? Y N When?_____

d. Have you ever had an Ear, Nose & Throat Evaluation? Y N When?_____

10. What medications are you currently taking? (List All)_____

_____

_____

11. Environmental History (Circle)

a. How long have you lived in your current home? _____ Year built?_____

b. Type of home (circle): House Apartment

c. Location (circle): City Suburban Rural

d. Is there a basement? Y N (Circle: Damp or Dry)

e. What kind of heating system? Radiator/Baseboard_____ Hot Air (Vents)_____

e. Bedroom: What floor is the bedroom on? _____ Is the bedroom carpeted (circle)? Y N

f. Type of Pillow:_____ Type of Comforter:_____ Any Down? Y N

g. Mattress (circle): Inner Spring Futon Water Foam

h. Do you have any allergy-proof covers for your pillows (circle)? Y N Mattress (circle)? Y N

i. Flooring (circle): Bare Floors Area Rugs Wall to Wall

Do you have the following:

a. Air conditioning ? Y N Central or Room(s)_____

b. Humidifier? Y N Where? _____

c. Animals in the home? Y N List_____

d. Tobacco smoke in the home? Y N Who? _____

12. If you have or suspect you have asthma, please answer the following:

a. Nighttime wheeze, cough, shortness of breath (circle): Occasional Often Never

b. Limitations & Symptoms (circle):

With sports & strenuous activity only With any activity Symptoms are present at rest

c. Number of school or workdays missed in the past year (approx.)?_____

d. Number of steroid (prednisone) prescriptions in the last year (approx.)?_____

e. Number of visits for asthma (lifetime): Emergency Room_____ Hospitalizations_____

f. History of "life-threatening" attacks (circle)? Y N Ever intubated (circle)? Y N

g. How often do you use your rescue inhaler?_____

h. Do you have a peak flow meter (circle)? Y N If so, what is your best peak flow?_____

Patient's Signature_____ **Date**_____

Doctor's Signature_____ **Date**_____