NEW PATIENT QUESTIONNAIRE
ALLERGY

1. Have you been evaluated for allergies before? □ No □ Yes If Yes, When? ______________________
What were your skin test results: ______________________
Have you had Immunotherapy before (allergy shots)? □ No □ Yes If Yes, When? ______________________
Have you ever received Cortisone Drugs (steroids i.e. prednisone®)? □ No □ Yes If Yes, When? ______________________
Have you ever had an Ear, Nose & Throat Evaluation? □ No □ Yes If Yes, When? ______________________

2. Medications: List all the prescription and over-the-counter medications that you take at home (such as cold medication, herbals, vitamins and nutritional supplements). If you have received a printed Medication list, please add here anything that is not on your printed list.

□ I take no medications or supplements □ See attached list

<table>
<thead>
<tr>
<th>Medication / Supplement Name</th>
<th>Dose</th>
<th>How you take it (by mouth, injection, etc.)</th>
<th>Time of day / How Often</th>
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3. Allergies: □ I have no allergies, sensitivities or medication reactions that I know of or
List all allergies, sensitivities and medication reactions. Include:
- medications • vaccinations • foods • insects / venom • bee sting • seasonal allergies
- substances such as latex • environmental allergies • reactions - including reactions to iodine or radiology contrast material

<table>
<thead>
<tr>
<th>Allergy / Sensitivity / Medication</th>
<th>Type of Reaction</th>
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<tbody>
<tr>
<td>Medication:</td>
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<td>Contrast / Dye:</td>
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<td>Food / Shellfish:</td>
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<td>Latex:</td>
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<td>Environmental:</td>
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<td>Bee Stings:</td>
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<td>Insects / Venom:</td>
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<td>Other:</td>
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4. Do you have any of the following symptoms?
□ Sneezing □ Blocked Nose □ Watery Nose □ Sputum (phlegm) □ Acid Stomach
□ Wheezing □ Cough □ Chest Tightness □ Shortness of Breath □ Watery Eyes
□ Rash □ Severe Itching □ Severe Swelling □ Hives □ Night Symptoms
Age when symptoms started? ___________ How long have you had these symptoms? ___________
5. Symptoms are worse during: (Check all that apply) □ No Change
   □ Jan □ Feb □ Mar □ Apr □ May □ June □ July □ Aug □ Sep □ Oct □ Nov □ Dec
6. Symptoms are worse: (Check all that apply)
   □ Mornings □ Afternoon □ Evenings □ Night □ At Home □ At Work □ Indoors □ Outdoors
7. Have you been told or do you think you have any of the following? (Check all that apply)
   □ Sinusitis □ Allergic Rhinitis / Hay Fever □ Nasal Polyps □ Recurrent Bronchitis □ Asthma
   □ Eczema / Rash □ Hives / Swelling □ Stomach Reflux □ High Blood Pressure □ Sleep Apnea
   □ Diabetes □ Tuberculosis □ Frequent Infections □ Ear Infections
   □ Other Medical Conditions: ____________________________________________
8. Which of the following bring on attacks of allergies or asthma? (Check all that apply)
   □ Air Conditioner □ Drafts □ Drugs □ Cigarette Smoke □ Allergens □ Cosmetics
   □ Exercise □ Fatigue □ Humidity □ Pollens □ Insecticides □ Wool
   □ Strong Odors □ Animals □ Molds □ Nervousness-Stress □ Respiratory Infections
   □ Alcoholic Beverages □ Other triggers: ________________________________
9. Please list any indoor or outdoor hobbies: ________________________________
10. Has anyone in your family ever had any of the following? □ No □ Yes  If Yes, please list who:
    □ Asthma ____________________ □ Eczema ____________________ □ Hay Fever ____________
11. Do you have asthma or suspect you might have asthma? □ No □ Yes  If Yes, please answer these questions.
    At night do you wheeze, cough, or have shortness of breath? □ Never □ Often □ Occasional
    Does your asthma cause problems with any of the following:
    □ Resting □ Sports and strenuous activity □ Any activity
    How many days of work or school have you missed in the past year? ___________________________
    How many steroid (prednisone) prescriptions have you had in the last year? ____________________
    How many times have you been to the Emergency Room for asthma? _______________________
    How many times have you been hospitalized because of asthma? __________
    Do you have a history of life-threatening attacks? □ No □ Yes
    Have you ever been intubated? □ No □ Yes
    How often do you use your rescue inhaler? □ Daily □ Weekly □ Monthly
    Do you have a peak flow meter? □ No □ Yes  If Yes, what is your best peak flow? ______
12. Your Home:
Where do you live?  □ Single Family  □ Apartment Housing  □ Assisted Living  □ Other
Where is your home?  □ City  □ Suburbs  □ Rural
How long have you lived in your current home?  ____________  What year was it built?  ____________
Is there a basement?  □ Yes  □ No  If No, is it  □ Damp or □ Dry
What kind of heating system?  □ Radiator / Baseboard  □ Hot Air (Vents)  □ Other  ____________
Do you have any of the following:
Air conditioning?  □ No  □ Yes  If Yes, is it  □ Central or □ Rooms
Humidifier?  □ No □ Yes If Yes, where?  ____________
Animals in the home?  □ No □ Yes If Yes, list them:  ____________
Tobacco smoke in the home?  □ No □ Yes If Yes, who smokes?  ____________

13. Your Bedroom:
What floor is your bedroom on?  ____________ Is your bedroom carpeted?  □ No □ Yes
What type of pillow do you use?  ____________ What type of comforter do you use?  ____________
What type of mattress do you use?  □ Inner Spring □ Futon □ Water □ Foam
Do you have any allergy-proof covers for your pillows?  □ No □ Yes  For your mattress?  □ No □ Yes
What type of flooring do you have? (check all that apply)  □ Bare floors □ Area rugs □ Wall-to-wall carpet

I have answered these questions to the best of my ability. I understand that this information will be used to guide my care.

X_________________________ ___________________________ OR
Patient’s Signature  Print Name
X_________________________ ___________________________
Signature of Person completing form for Patient Print Name  Relationship to Patient
Date: ___/___/___  Time: ____ : ____  o.a.m.  o.p.m.

Name of Interpreter (if applicable):_________________________