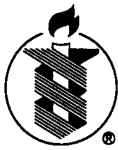


Beth Israel Deaconess Medical Center
Boston, MA 02215

NEW PATIENT QUESTIONNAIRE
ALLERGY

PATIENT'S NAME ______________________

MED. REC. # ______________________

DOB ______________________

Patient Identification

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? __________

MR2782

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**

Medication / Supplement Name	Dose	How you take it (by mouth, injection, etc.)	Time of day / How Often

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

Allergy / Sensitivity / Medication	Type of Reaction
Medication:	
Medication:	
Contrast / Dye:	
Food / Shellfish:	
Latex:	
Environmental:	
Bee Stings:	
Insects / Venom:	
Other:	

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? __________

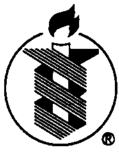
How many times have you been hospitalized because of asthma? ________

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? _____



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ALLERGY

PATIENT'S NAME ______

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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 ______ Patient's Signature ______ Print Name **OR**

X ______ Signature of Person completing form for Patient ______ Print Name and ______ Relationship to Patient

Date: ___/___/___ **Time:** ___ ___ : ___ ___ ○ a.m. ○ p.m.

Name of Interpreter (if applicable): ______