Health Questionnaire

Welcome!
We are glad you have chosen The Asthma & Allergy Institute.

The Asthma & Allergy Institute is pleased to provide this self-directed form which will greatly increase the speed in which you are seen, while providing a comprehensive overview of your current health status (or that of your child). We look forward to **caring for you** today.

PATIENT INFORMATION

Is this form being completed by the patient ❑ or a parent ❑ or guardian ❑ ? (Check one)

Today's Date: _____

Name:_____

Age:_____ **Date of Birth:** _____

Have you been seen in this office in the last three years? ❑ Yes ❑ No

When?_____

PRIMARY PROBLEM: What is the main medical problem that prompted your office visit today? Please list one only.

- ❑ **Ears**
- ❑ **Eyes**
- ❑ **Head**
- ❑ **Gastrointestinal**
- ❑ **Other:**
- ❑ **Lungs**
- ❑ **Nose**
- ❑ **Skin**
- ❑ **Throat**

List symptoms you are experiencing today .

Involving the **head**? ❑ NO ❑ YES
❑sinus headache over the eyes ❑sinus infections
❑sinus headache behind the eyes ❑sinus headache on top of head
❑sinus headache in back of head ❑sinus headaches on sides of head
❑migraine headaches ❑sinus headache in the cheeks

Involving the **eyes**? ❑ NO ❑ YES
❑ itching ❑ redness ❑ swelling
❑ tearing ❑ blurring ❑ burning
❑ dryness ❑ blinking

Involving the **ears**? ❑ NO ❑ YES
❑ recurrent ear infections ❑ tubes in ears currently ❑fluid in ears
❑ tubes in ears in past ❑ tubes in ears more than once ❑ pain in ears
❑ pulling at ears ❑ speaks loudly

Involving the **nose**? ❑ NO ❑ YES
❑ decreased sense of smell ❑ runny nose ❑ stuffy nose
❑ decreased sense of taste ❑painful nose ❑ bloody nose
❑ post-nasal drip ❑ sneezing ❑ snoring
❑ polyps

Involving the **throat**? ❑ NO ❑ YES
❑ recurrent sore throats ❑ history of throat swelling ❑throat clearing

Care Providers Comments:

❑ recurrent laryngitis ❑ sensation of throat closing ❑excessive mucus

Involving the **lungs**? ❑ NO ❑ YES

❑ difficulty taking deep breath ❑ shortness of breath ❑ wheezing
❑ chest tightness ❑ chest heaviness ❑ coughing
❑ breathlessness ❑ nighttime asthma ❑chest pain
❑ nighttime shortness of breath ❑ nighttime coughing ❑ sighing
❑ exercised induced asthma ❑ exercise induced short of breath ❑ asthma
❑ exercise induced coughing ❑ exercise induced breathlessness ❑ infections
❑shortness of breath with daily activities
❑ shortness of breath with strenuous activities

Involving the **gastrointestinal tract**? ❑ NO ❑ YES

❑ bloating ❑ abdominal pain ❑ stomachaches
❑ diarrhea ❑ recurrent vomiting ❑ gas
❑ bloody bowel movements ❑ constipation ❑ nausea
❑ belching

Involving the **skin**? ❑ NO ❑ YES

❑ itching ❑ recurrent skin rashes ❑ hives
❑ excessive dryness ❑ flaking skin (eczema/psoriasis) ❑ infections

Involving the **joints**? ❑ NO ❑ YES

❑ swelling ❑ pain ❑ stiffness

DURATION: How long has this problem existed: (please circle correct response)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16-20 >20

days weeks months years

SEVERITY: In your estimation, how severe are these symptoms?

❑ Mild ❑ Moderate ❑ Severe

SEASON: During which seasons of the year are your symptoms worse?

❑ year round ❑ spring ❑ summer ❑ fall ❑ winter

PLACE **Where are symptoms noted more?**

❑ no particular place ❑ outside ❑ inside ❑ at home ❑ at work
❑ at school ❑ when shopping ❑ at church ❑ at a relative's home (indicate) _____
❑ other (please specify) _____

TIME **When are symptoms worse?**

❑ during the daytime ❑ in the morning ❑ in the afternoon ❑ during the nighttime
❑ during the weekday ❑ during the weekend ❑ other(please indicate) _____

AGGRAVATING FACTORS **What factors worsen symptoms?**

Allergens
❑ dust ❑ mold Pollen
❑ birds ❑ cats ❑ grass
❑ rabbits ❑ dogs ❑ tree
❑ hamsters/guinea pigs ❑ weed

Irritants
❑ smoke ❑ perfume
❑ detergents ❑ strong chemicals
❑ soaps ❑ others _____

Weather
❑ cold ❑ heat
❑ rain ❑ fog
❑ dry conditions ❑ windy conditions
❑ low humidity ❑ high humidity
❑ cloudy conditions ❑ changing temperatures

Activities
❑ daily activities ❑ strenuous activities ❑ running
❑ walking short distances ❑ walking quickly ❑ playing
❑ running long distances ❑ walking up stairs ❑ other

Care Providers Comments:

SENSITIVITY HISTORY **Are you aware of any specific sensitivities?** ☐ **NO** ☐ **YES** (Please indicate)

CONTACT SENSITIVITY

❑ poison ivy ❑ nickel ❑ gold
❑ silver ❑ rubber/latex ❑ leather
❑ plants ❑ chemicals ❑ other materials/fabrics
❑ other :

STINGING INSECT SENSITIVITY ❑ bee sting ❑ fire ant ❑ spider ❑ yellow jacket ❑ wasp ❑ other: _____

FAMILY HISTORY **Is there a family history of previous allergies / allergy treatment?** ☐ **NO** ☐ **YES**

❑ Asthma	❑ mother	❑ father	❑ brothers/sisters	❑ grandmothers	❑ grandfathers	❑ aunts	❑ uncles
❑ Rhinitis (Hay fever)	❑ mother	❑ father	❑ brothers/sisters	❑ grandmothers	❑ grandfathers	❑ aunts	❑ uncles
❑ Skin allergy	❑ mother	❑ father	❑ brothers/sisters	❑ grandmothers	❑ grandfathers	❑ aunts	❑ uncles
❑ Food allergy	❑ mother	❑ father	❑ brothers/sisters	❑ grandmothers	❑ grandfathers	❑ aunts	❑ uncles
❑ Ear infections	❑ mother	❑ father	❑ brothers/sisters	❑ grandmothers	❑ grandfathers	❑ aunts	❑ uncles

❑ Other (please specify) _____

ENVIRONMENTAL HISTORY

Do you live in: ❑ a house ❑ an apartment ❑ trailer ❑ other _____

Located: ❑ rural area ❑ urban/city area ❑ near factory/industry ❑ near ocean/lake/river

SOCIAL HISTORY

Tobacco use: NO YES cigarettes cigars pipe snuff How many years? _____
# of cigarette packages a day:_____
Have you ever smoked in the past? NO YES How many years? _____ # of cigarette packages a day:_____
Do you drink? NO YES If YES, please indicated which kinds?
beer wine mixed drinks
How often do you drink? daily on weekends socially

SERIOUS MEDICAL PROBLEMS **Is there a history of any serous medical problems?** ☐ **NO** ☐ **YES**

(please check all that apply)

diabetes controlled with insulin	diabetes controlled with oral medication	heartburn
diabetes controlled with diet	high blood pressure	COPD
skipped heart beats	angina or heart pain	asthma
previous heart attack	heart failure	reflux
mitral valve prolapsed	stroke	HIV
hyperthyroidism	hypothyroidism	hepatitis

other heart conditions (please specify) _____
fainting (indicate why) _____
seizures or epilepsy (type, if known) _____

IMMUNIZATION HISTORY **History of previous immunizations?** ☐ **No** ☐ **Yes**

❑ Flu Date received: _____ Facility given:_____
❑ Pneumovax Date received: _____ Facility given: _____

PREVIOUS ADRENALIN USE **Is there a history of previous use of Adrenalin / Epinephrine?** ☐ **No** ☐ **Yes**

PAST MEDICAL HISTORY **(List all in order of most recent first.)**

Is there a history of previous surgery? ❑ **NO** ❑ **YES**

1. date _____
2. date _____
3. date _____

Is there a history of previous DRUG allergy and reaction? ❑ **NO** ❑ **YES**

1. date _____
2. date _____
3. date _____

Please list specific foods which are not tolerated and which symptoms are noticed if eaten:

Food	*Symptom(s)*

CURRENT ALLERGY MEDICATIONS **Medicines currently being used to control allergy symptoms? N Y**

Allergy Medicine	Frequency	Effectiveness
1.		(not) 1 2 3 4 5 (very)
2.		(not) 1 2 3 4 5 (very)
3.		(not) 1 2 3 4 5 (very)
4.		(not) 1 2 3 4 5 (very)
5.		(not) 1 2 3 4 5 (very)
6.		(not) 1 2 3 4 5 (very)
7.		(not) 1 2 3 4 5 (very)
8.		(not) 1 2 3 4 5 (very)
9.		(not) 1 2 3 4 5 (very)
10.		(not) 1 2 3 4 5 (very)

List of All Current Medications

Name	Dosage	Daily Amount